Government of the District of Columbia
Department of Mental Health
Supportive Housing Strategic Plan
2012 – 2017

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Completed by:
Technical Assistance Collaborative

Prepared for:
The Department of Mental Health

TAC
TECHNICAL ASSISTANCE COLLABORATIVE

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I. Introduction

A. Overview of the Task/Key Objectives of the Plan

The Washington, D.C. Department of Mental Health (DMH) has committed its efforts to developing a system that supports individuals with mental illness in integrated, community-based settings. Accordingly, DMH recognizes the important role that community-based housing – particularly Permanent Supportive Housing – has in achieving this objective. The United States Substance Abuse and Mental Health Services Administration (SAMHSA) describes Permanent Supportive Housing (PSH) as "decent, safe, and affordable community-based housing that provides tenants with the rights of tenancy under state and local landlord tenant laws and is linked to voluntary and flexible support and services designed to meet tenants' needs and preferences."[1]

In April 2012, DMH initiated a process to evaluate its current system of DMH-supported housing and to identify strategies to ensure a continuum of community-based housing and support services that meet consumer needs, are built on best practices, are consistent with DMH priority population needs, and are cost-effective.

DMH retained The Technical Assistance Collaborative, Inc. (TAC) through a competitive Request for Proposals (RFP) process to facilitate a strategic planning process with stakeholders, DMH staff, and other partners that would result in a strategic plan that includes a series of recommendations for DMH to work from as it advances its supportive housing objectives over the next five years.

Between April and June 2012, TAC evaluated the current system of housing and supports for individuals with serious mental illness, engaged stakeholders through a workgroup process, interviewed key informants and met with DMH leadership and key staff to formulate strategic recommendations.

The result of this work is the five year Strategic Supportive Housing Plan, a document that establishes the guiding strategies for DMH's future activity in PSH and contains specific actions to be implemented by DMH. This Strategic Supportive Housing Plan will not be a static document but will evolve over the next five years as circumstances dictate.

DMH would like to thank the workgroup members and other key stakeholders who participated in this process for their frank, honest feedback during meetings and interviews, and for their commitment and desire to strive for the strongest system possible. A list of workgroup members and other key informants is included in **Appendices B and C**.

B. Policy Framework for DMH Strategy

Like other jurisdictions across the country, DMH is responsible for managing a public mental health system that meets the diverse needs of its residents. Whereas the mental health needs of individuals are frequently complicated by other complex social problems, DMH has had to venture into non-traditional areas in order to best meet the needs of individuals. Often, this means directly providing rental assistance and capital funding or playing a central role in organizing housing-related resources so that consumers have access to quality, affordable housing. Part of this strategic planning process was to help DMH re-balance its responsibilities as the mental health authority and its role in housing.

[1] SAMHSA. (2010). Permanent Supportive Housing Evidence-Based Practices (EBP) KIT. PowerPoint Presentation: http://store.samhsa.gov/product/SMA10-4510.

DMH has demonstrated a commitment to enabling people with mental illness served by the Department to live in integrated, community-based settings. Over the past several years, DMH has substantially increased its capital and rental assistance funding for PSH. In Fiscal Year 2013, DMH added another $5 million to its capital funding pool, bringing the total amount allocated to this program to $19 million, and added an additional $1.2 million to the DMH Home First Program. Between Fiscal Years 2012 and 2013, DMH created 300 new Home First rental subsidies. Approximately 54% of DMH's housing resources provide funding to individuals in PSH settings with the other 46% supporting agency operated residential programs such as Community Residential Facilities (CRFs) and contracts to agencies for Supported Independent Living (SILs).

The move toward PSH is consistent with best practice. While DMH has articulated the need to provide a continuum of residential options for individuals based upon their needs, it desires to increase its emphasis on the use of PSH within its system for individuals with a range of mental health needs. PSH is known to be effective for a wide range of individuals who need intensive supports, including those with severe mental illness who are chronically homeless, those leaving long-term hospitalization, and those who are highly symptomatic. For the sake of brevity of this report, a list of resources demonstrating the effectiveness of PSH is attached in **Appendix H**.

Further, the emphasis on true community integration and the increasing acceptance of person-centered, recovery-oriented services at the federal, state, and local level is pushing jurisdictions like the Department of Mental Health to create systems of housing and services that enable individuals to lead normalized, non-segregated lives in communities of their choice. The literature also suggests that the move toward integrated, PSH settings is also more cost-effective than older, more traditional program and staffing-based models of residential care.

This strategic plan comes at an important time for DMH. In February, 2012, the Department entered into a Settlement Agreement, ending from the long standing *Dixon* case which dates back to 1974.[2] One of the requirements of the Agreement was to develop a strategic plan to address the needs for supportive housing within the District. This Supportive Housing Strategic Plan is intended to satisfy that requirement.

Earlier this year, Mayor Vincent Gray established the Comprehensive Housing Strategy Task Force (HTF).[3] In creating the HTF, Mayor Gray stated, **"**The goal of the Comprehensive Housing Strategy Task Force is to help city leaders ensure the creation of more affordable housing for residents of the District of Columbia." The DMH Supportive Housing Strategic Plan contains several strategies to maximize the use of various funding sources for housing development that can inform this district-wide process.

Over the past several years, DMH has structured its service delivery system through the Mental Health Rehabilitation Services (MHRS) option. While the MHRS is a Medicaid-based system, it does support eligible District residents who do not have Medicaid and does not pay for non-Medicaid eligible services. Even though the range of services offered through MHRS is designed to support individuals in independent, community-based settings is consistent with the PSH model. "The Department's goal is to deliver mental health services that promote recovery, respect cultural and linguistic diversity, and are choice-driven through the Mental Health Rehabilitation Services system for community-based care. The MHRS system is based on individualized services and supports."[4]

[2] Dixon Settlement Agreement; http://dmh.dc.gov/dmh/frames.asp?doc=/dmh/lib/dmh/pdf/DixonSettlementAgreement/Settlement_Agreement.pdf
[3] Comprehensive Housing Strategy Task Force: http://www.taskforce2012.org/Purpose/tabid/250/Default.aspx
[4] DMH webpage: http://www.dmh.dc.gov/dmh/cwp/view,a,3,q,515826,dmhNav,%7C31250%7C.asp

The strategies in this report build on this policy framework, and help position DMH to achieve its objectives of facilitating a continuum of integrated, affordable housing options for people with mental illness, and serving as many people in PSH as possible.

II. Methodology

In order to assist with the development of the strategic plan, DMH issued a competitive Request for Proposals in February 2012. The Technical Assistance Collaborative, Inc. (TAC), a Boston-based, nonprofit consulting firm, was awarded the contract and began facilitating the strategic planning process with the Department in April 2012. Between April and June 2012, a TAC team of multi-disciplinary professionals with expertise in mental health and affordable housing systems met with DMH staff, stakeholders, and other government agencies within the District to help formulate the basis for the strategic recommendations identified in this report.

As part of this strategic planning process, DMH requested that TAC incorporate the following components as a framework for the Strategic Supportive Housing Plan:

1. A description of the range of housing offered to individuals with a severe mental illness, including a description of the DMH's full array of services and other services that should be offered by the Department;

2. An inventory of both supportive and non-supportive housing offered by DMH and other District agencies and/or providers for individuals with a severe mental illness. This includes the identification of areas of duplication, gaps in services and unmet needs, and a description of specific strtaegies to meet identified unmet needs;

3. A uniform and objective methodology for evaluating need for supportive housing, establishing different levels of priority of need, and assigning all supportive housing using the proposed methodology and system of prioritization;

4. A description of a proposed mechansim for determining the need for supportive housing, including an articulation of the eligibility requirements that should be used to distribute available housing vouchers and other supports;

5. A proposed strategy for integrating the services of Peer Specialists into the housing service delivery system to assist individuals with mental illness to move to a less restrictive alternative housing option and to maintain community tenure; and

6. Development of a five-year plan to expand housing.

A. Planning with DMH Staff

TAC met with DMH leadership, including DMH Director Steve Baron and Senior Deputy Director Dr. Barbara J. Bazron, and with housing and program staff at a kick-off meeting on April 12, 2012, and on several other occasions throughout the process to evaluate findings, debrief on workgroup meetings and key informant interviews, and formulate strategic actions. Director Baron and Senior Deputy Director Bazron also facilitated access to key informants in the Mayor's office, the District's Housing Finance Agency (DCHFA), and various providers.

B. Housing and Services Inventory Analysis

Over the years, various assessments of the public mental health system in Washington, D.C. have been conducted that continue to move the system to a recovery-orientation. Among these are two reports from RAND: *A Guide to the Behavioral Health System in the District of Columbia* and *Behavioral Health in the District of Columbia: Assessing Need and Evaluating the Public System of Care* (October 2010)[5] that broadly assessed the behavioral health system and provided useful background information for this focused planning effort.

As part of this process, TAC specifically evaluated the current array of housing and housing-related supports in order to inform the thinking of the workgroups and DMH staff, and to better understand existing pathways and operations in order to identify potential areas for improvement. The consultants reviewed various sources of information, including budget documents, regulations, contracts, existing housing inventory information, federal housing and services data and grant information, census data, Requests for Proposals, and provider documents related to DMH housing programs. In addition, regulations, contracts, the SAMHSA block grant, DMH program summary documents, census data, and budget information were reviewed. Key informant interviews were conducted for both housing and services to inform the planning process and to formulate the recommendations to be contained within the Supportive Housing Strategic Plan.

C. Stakeholder Participation and Meetings with Key Informants

Consumers and other stakeholders were actively involved in the planning process. As a result, this effort included: four separate workgroups with 51 different stakeholders representing various groups; 32 key informant interviews; a focus group of housing operators; and numerous phone calls and on-site discussions with DMH staff. Stakeholders from various interested groups included housing and service providers, consumers, family members, advocates, and other relevant District agencies. Key informant interviews included specific provider agency staff, housing developers, and staff within Mayor Gray's office. The focus group with housing operators of Independent CRFs discussed the issues that they experience when providing housing to people with mental illness and working with provider staff.

The general purpose of the workgroups was to provide guidance and information to be used by TAC to develop a series of recommended strategies for DMH to consider. At the kick-off meeting for each workgroup, a PowerPoint (**Appendix E**) was presented that briefly described this process and preliminary findings relevant to each group. (See **Appendices B, C, and D** for a list of workgroup members, key informants interviewed, and workgroup descriptions and summaries.) The four workgroups included:

1. Housing Utilization and Maximization Workgroup: This workgroup explored ways to increase and maximize the supply of affordable housing.

2. Service Needs and Realignment Workgroup: This workgroup identified strengths, duplication, and gaps in the residential services continuum and suggested ways to improve the continuum of residentially-based services.

3. Supportive Housing Eligibility and Allocation Workgroup: This workgroup examined mechanisms to establish uniform and equitable eligibility and allocation criteria for PSH.

[5] RAND: http://www.rand.org/content/dam/rand/pubs/technical_reports/2010/RAND_TR914.sum.pdf, and: http://www.rand.org/pubs/working_papers/2010/RAND_WR777.pdf

4. Workforce and Training Workgroup: This workgroup examined workforce issues in PSH settings and suggested mechanisms to increase the competency and quality of the workforce in residentially-based settings.

D. DMH Needs Assessment

To help inform DMH, as well as the Mayor's Comprehensive Housing Strategy Task Force, TAC developed a methodology to identify the affordable housing and permanent supportive housing (PSH) needs for people with mental illness living in the District. The methodology and needs assessment is further detailed in Section IV. The intent of this process was to: 1) establish an estimate of the supply of affordable housing that should be available in the District to meet the affordable housing needs of people with mental illness; and 2) establish an estimate of PSH still needed for people with mental illness living in the District.

III. Baseline Description of Housing and Services

Section A below provides a description of the range of housing offered to individuals with a serious mental illness, including an inventory of both supportive and non-supportive housing offered by DMH and other District agencies and providers. Section B presents the array of services and ancillary supports available to consumers.

A. Description of Available Permanent Supportive Housing (PSH)

DMH and other District of Columbia agencies and other partner entities have developed an array of PSH that is available to DMH priority consumers. This includes a total of 2,434 PSH units throughout the District. The breadth and array of PSH available is a real strength of the system. In addition, DMH and its provider network have embraced and offer a broad range of PSH which is often not the case in many communities that still maintain rigid allegiance to outdated housing models. As a byproduct of the range and quantity of PSH options available, there are several pathways or entry points to access these PSH opportunities, including PSH programs sponsored by DMH, the D.C. Department of Human Services (DHS), or specific providers (e.g. funded directly by the HUD McKinney-Vento Supportive Housing Program Below is a baseline discussion of the PSH resources in the District, as well as, a description of other housing services available to consumers.

1. DMH-Sponsored Permanent Supportive Housing (PSH)

Home First Rental Assistance Program – DMH provides 675 Home First tenant-based vouchers for DMH priority consumers. The purpose of the Home First program is to provide a temporary rent subsidy until the consumer is able to access a Section 8 Housing Choice Voucher. The Home First program generally mirrors the Section 8 Housing Choice Voucher Program except that contract rents are capped at 80% of FMR. The D.C. Public Housing Authority (DCHA) administers the rental assistance on behalf of DMH. The DMH Housing staff serves as the access point and manages the waiting list for the Home First vouchers.

Local Rent Subsidy Program (LRSP) – DCHA administers 121 project-based rent subsidies assigned to nine DMH-sponsored projects. These projects accept referrals of DMH priority consumers for these targeted units. The District of Columbia locally provides the resources to support the LRSP vouchers.

DCHA Partnership Program/Section 8 Project-Based Vouchers – DCHA administers its Section 8 Project-Based Voucher Program, named the Partnership Program. There are 117 project-based vouchers assigned to 11 DMH-sponsored projects. Referrals are made by both DMH and its Core Service Agencies (CSAs).

Shelter Plus Care Program – DMH is the grantee for 15 Shelter Plus Care tenant-based subsidies targeted to homeless individuals with serious mental illness. The Community Partnership administers the Shelter Plus Care Program on behalf of DMH.

2. DCHA-Sponsored Permanent Supportive Housing (PSH)

Non-Elderly Disabled Vouchers – The D.C. Housing Authority (DCHA) oversees and administers 200 non-elderly disabled (NED) vouchers on behalf of the District of Columbia. Of this allocation, DCHA targets 182 of these tenant-based Section 8 vouchers for DMH priority consumers. DMH coordinates referrals to DCHA for these housing resources.

St. Elizabeth's Hospital Section 8 Housing Choice Voucher Set-Aside – As part of its Section 8 Housing Choice Voucher Program, DCHA has elected to establish a Section 8 set-aside for 50 tenant-based vouchers made available for non-elderly persons with a disability who are making the transition from St. Elizabeth's Hospital to community-based living. DMH coordinates referrals to DCHA by identifying eligible DMH consumers from St. Elizabeth's Hospital.

Chronically Homeless Set-Aside – As part of its Section 8 Housing Choice Voucher Program, DCHA has also established a Section 8 set-aside for up to 447 tenant-based vouchers for chronically homeless individuals and families. As part of this, 75 tenant-based vouchers are set-aside for chronically homeless individuals with serious mental illness. DMH makes the referrals to DCHA to take advantage of this resource when available.

Mainstream Disability Vouchers – DCHA was competitively awarded 100 tenant-based vouchers through HUD's Mainstream Program. These tenant-based vouchers must be utilized by persons with a disability. Forty of these tenant-based vouchers are set-aside for persons with a serious mental illness. DMH coordinates all referrals to DCHA upon turnover.

3. D.C. Department of Human Services-Sponsored Permanent Supportive Housing (PSH)

DHS Permanent Supportive Housing Program – The D.C. Department of Human Services (DHS) manages the Permanent Supportive Housing program (PSHP) serving 800 homeless individuals and 250 families. The program offers a rental subsidy linked with case management services provided by DHS. DHS assesses and coordinates access to the PSHP using a vulnerability index (VI) assessment tool to identify the "most in need" households. The District of Columbia supports the program with local resources.

4. The Community Partnership (TCP)-Sponsored Permanent Supportive Housing (PSH)

TCP's Shelter Plus Care Program – As part of the District's homeless Continuum of Care, the Community Partnership (TCP) administers the Shelter Plus Care resources comprised of 1,650 rent subsidies for homeless individuals and families with a disability. Many of these S+C vouchers serve homeless individuals with serious mental illness. TCP manages the waiting list and referral process for these housing resources with its homeless service provider network. Many of these service providers are also DMH Core Service Agencies (CSAs).

5. DMH Provider Owned and Managed Housing

DMH Provider Owned and Managed Housing – Several DMH providers own and manage supportive housing for individuals with serious mental illness. These housing options are typically comprised of site-based PSH projects. The providers manage these PSH units and coordinate the outreach and referral to identified eligible tenants. These projects have received capital financing and operating subsidy support from a variety of sources including HUD homeless vouchers for the disabled and DMH subsidy and capital funding.

Tables 1 and **2** below provide an inventory of PSH and other DMH housing programs. This information is used in Section IV to develop an assessment of affordable housing and PSH need for consumers with mental illness living in the District.

TABLE 1: NUMBER SERVED IN PSH IN DMH OR OTHER HOUSING PROGRAMS

Program	Numbers Served in PSH (High Estimate)	Numbers Served in PSH (Low Estimate)
DMH Programs		
Supportive Housing - Home First	675	675
Supportive Housing – LRSP	121	121
Supportive Housing – DCHA Partnership Program (Section 8 PBV)	117	117
Supportive Housing – S+C	15	15
Supportive Housing – Non-Elderly Disability Vouchers	182	182
Supportive Housing – St. Elizabeth Section 8 Set-Aside	50	50
Supportive Housing – Chronic Homeless Set-Aside	75	75
Supportive Housing – Mainstream Vouchers	40	40
Non-DMH Programs (Estimated % MI)		
DHS PSH (800)	480*	264**
The Community Partnership (1,650)	990*	544**
Provider Managed Housing	351	351
Total	**3,096 (high)**	**2,434 (low)**

* Based on USICH estimates that 60% of those who experience chronic homelessness have current or past mental illness.
** Rather than use 60% estimate, a 33% estimate was used.

TABLE 2: NUMBER SERVED IN OTHER DMH HOUSING PROGRAMS

Program	FY 12 Capacity
Contract Community Residential Facilities (C-CRFs)[6]	221
Independent Contract Residential Facilities (I-CRFs)[7]	468
Supportive Independent Living (SIL)[8]	397
Total	**1,086**

B. Description of Available Services & Supports

DMH consumers have access to an array of available service resources to support housing stability in the community. These include DMH housing-related services delivered in residential and non-residential settings, as well as non-DMH resources for housing-related services and supports. The system strengths, challenges, and opportunities that have been identified with regard to service access and coordination are briefly mentioned here and are further elaborated upon in the strategic recommendations section of this report.

1. Standardized Assessment Tool

All adult consumers seeking or enrolled in mental health services receive an individualized assessment that includes the administration of a standardized tool called the LOCUS (Level of Care Utilization System). The LOCUS is "designed to create a level of care recommendation based on a multi-dimensional functional assessment of individual consumers. The LOCUS provides a framework for determining the appropriate nature and intensity of services and resources to meet consumer needs."[9] Core Service Agencies (CSAs) are responsible for conducting the LOCUS assessments at: intake; at regular intervals (i.e. every 90 days); whenever a change in service is requested that requires authorization; or on an as-needed basis.[10]

2. DMH Housing-Related Services: Residential Based

Presently, DMH consumers have access to three types of residentially-based services: Contracted Community Residential Facilities (C-CRFs), Independent Community Residential Facilities (I-CRFs) and Supported Independent Living (SIL). These programs are structured as non-supportive housing, though SIL has elements of supportive housing. Each varies in terms of the level and type of services provided to consumers as well as the housing setting, with the most variation occurring in the SIL program which offers a mix of residential and more independent apartment options. DMH has identified consumers pending discharge from Saint Elizabeth's Hospital; homeless consumers with serious mental illness; and

[6] These are group home facilities
[7] These are group home facilities
[8] These are scattered-site apartments and single room occupancy dwellings
[9] DMH background statement on LOCUS: https://docs.google.com/document/d/1mN0Tq3K6kPJkVX1w6MxUZfaP4LLnasPcVKotYpUFKT8/edit?hl=en_US&pli=1
[10] DMH Policy 300.1: http://dmh.dc.gov/dmh/frames.asp?doc=/dmh/lib/dmh/pdf/TrainingInstitute/LocusCalocus/DMH_Policy_300.1_TL-70_-_L_-LOCUS_CALOCUS.pdf

consumers who are moving to a less restrictive environment as its priority populations within the total range of housing and residential services.

Contracted Community Residential Facilities (C-CRFs) provide structured housing supports in a supervised residential setting. DMH currently contracts with five providers with a total capacity to serve 221 consumers. Providers receive $1,083 per month (SSI $698 + State Optional Supplement $485) from the consumer and a negotiated per diem from between $78 - $82 through their DMH contract.[11] Services offered in these settings include "24-hour awake" supervision, medication monitoring, assistance with money management, access to treatment and medical care, and assistance with activities of daily living to assist consumers in achieving a greater level of independence. DMH also contracts with one provider to operate twelve transitional CRF beds at a rate of $51 per day. The intent of the program is to prepare consumers for moving to more independent living; however, the program has functioned more like long term group housing.

- ***CTI Step Down Pilot –*** Following recommendations from the DMH created Community Residential Facility (CRF) Task Force which was established in April, 2010(See **Appendix G** regarding CRFs), DMH recently began a pilot initiative to step down thirty consumers from CCRFs to supportive housing using an adaptation of the Critical Time Intervention (CTI) model. Three DMH staff (one Care Manager from the Integrated Care Division and 2 Peer Transition Specialists) are providing an 'overlay' (i.e. in addition to the assigned CSA and treatment team) of time-limited (9 month) services to support the successful transition of these individuals from congregate care to supportive housing. DMH has devised a clear reinvestment strategy that will result from the reduction in C-CRF beds with 1/3 being used to develop a flexible fund pool to be managed by DMH for non-billable housing related activities, 1/3 to develop new housing subsidies, and the remaining 1/3 to preserve capacity for consumers that require a C-CRF level of care.

Independent Community Residential Facilities (I-CRFs) are operated by private housing owners/operators and have current capacity to serve 468 consumers. Services include 24-hour supervision, monitoring, and assistance with transportation and activities of daily living. While DMH licenses I-CRFs, they are not expected to provide the same level of services that CCRFs do. Consequently, I-CRFs receive the same $1,083[12] per month from consumers for room, board and support, but do not receive any additional per diem allowance. DMH has promulgated a rule that will provide these providers with $10.00 per day to provide the additional supports required by individuals who are residing in these facilities that need a Contract Residential Facility level of care. It is anticipated that these funds will be available to I-CRFs during the first quarter of FY13.

Supported Independent Living (SIL) provides congregate or independent living with minimal supervision and some monitoring. The program has the capacity to serve 397 consumers and is operated somewhat differently across the six providers DMH currently contracts with who receive $13.50 per diem to provide supports needed to assist consumers in transitioning to a less restrictive level of care. Services include at least weekly home visits from a Community Support Worker and assistance with life skills activities based on individual needs. (See Appendix F)

3. DMH Housing-Related Services: Non-Residential Based

[11] Consumers receive $100 per month personal needs allowance out of this total.
[12] Consumers in I-CRFs also receive $100 per month personal needs allowance out of this total.

Peer Transition Specialists – The DMH conducts a Peer Certification Specialists program. Individuals who have self-identified as having received or are presently receiving mental health services in personal recovery and have undergone certification training by DMH on how to assist others in recovery and resiliency and pass a competency exam are certified as Peer Specialists. Under general supervision, a certified Peer Specialist performs a wide range of tasks to assist individuals to regain control over their lives and their own recovery process. To date, 22 persons in recovery have been certified as Peer Specialist.

Currently, these individuals provide 1:1 support and intervention for consumers, help individuals enrolled in the public mental health system to acquire daily living skills in the DMH Training Apartment, and implement the Critical Time Intervention methodology to assist consumers in their transitions to the community. Peers also participate in involuntary medication panels.

CSA Housing Liaisons – CSAs are responsible for referring consumers with housing needs to DMH as appropriate. Ten of the 25 CSAs have the capacity to designate a Housing Liaison, an agency-supported position that serves as the central point of contact for accessing DMH housing resources. The role of Housing Liaisons varies by CSA. They perform many functions (e.g., some carry caseloads in addition to their housing responsibilities) and serve as a resource within their agency regarding the availability of housing resources, application and referral processes, and as point of contact with DMH on housing-related issues including level of care determinations and monitoring/ troubleshooting of consumer housing and clinical issues as they arise.

Mental Health Rehabilitation Services (MHRS) – DMH provides a range of community-based outpatient services for consumers through its Medicaid-funded MHRS program. MHRS services are provided by a network of 37 DMH-certified community providers, (25 Core Service Agencies (CSAs), 10 sub-providers, and 15 specialty providers)[13] that provide specified MHRS services. Consumers served in both DMH residential and supportive housing programs typically receive one or more of these services which include: Diagnostic Services, Intensive Day Treatment, Community-Based Intervention, and Assertive Community Treatment (ACT).

The primary MHRS services used to support people in community-based housing are Community Support and Assertive Community Treatment (ACT). Community Support Workers (CSWs) provide much of the supports to consumers in DMH housing programs. These services are designed to assist consumers of mental health services to achieve rehabilitation and recovery goals. DMH significantly expanded ACT teams over the past several years, and now funds seven providers to operate a total of 15 ACT teams with a capacity of 1,450 consumers. ACT is an intensive, integrated, rehabilitative, crisis, treatment and mental health rehabilitative community support service provided twenty-four hours per day, seven days per week to individuals with who require significant support to function successfully in the community.[14] Individuals in DMH-supported housing have the benefit of these flexible Medicaid plan services. However, providers are varied in their ability to maximize Medicaid billing for housing-related service provision and the opportunity exists to enhance this capacity among providers.

PUSH Funds – DMH also offers PUSH bridge fund loans that may be requested for consumers being discharged from Saint Elizabeth's to Community Residential Facilities. These are short-term (3 month)

[13] Some providers hold several types of MHR certifications. For example, a CSA may also be certified as a specialty provider.
[14] MHRS definition of ACT: http://www.dmh.dc.gov/dmh/frames.asp?doc=/dmh/lib/dmh/pdf/website_mhrs_services.pdf

loans made by DMH to consumers and paid to CRF operators which are then repaid from initial Social Security benefits payments to consumers.

New Directions Program – The New Directions Program at Washington Hospital Center was established to provide a higher level of support for individuals who have experienced long term episodes of care at Saint Elizabeth's and are being discharged to the community. The program is designed to provide a creative approach to service delivery utilizing mental health and non-mental health services and supports. The work is supported by a case rate payment methodology allowing flexible funds to do "whatever it takes" to ensure consumers stay in their communities and families to their maximum ability and desire. Currently, this program has the capacity to serve 30 individuals.

Benefits Assistance & Representative Payee Services – DMH operates the D.C. SSI/SSDI Outreach, Access and Recovery Services (SOARS) project which assists consumers who have experienced homelessness with accessing Social Security Administration benefits. The Initiative developed a plan to improve processing times for access to SSI/SSDI benefits, and conducted training for case workers who assist consumers in applying for benefits. Additionally, DMH contracts with Bread for the City to manage a representative payee program for 800 consumers who are referred by a DMH case manager or CSA. Upon enrollment, Bread for the City applies to the Social Security Administration or Office of Personnel Management to become the client's representative payee. The consumer's mental health case manager then meets regularly with the consumer to review his/her monthly budget, and informs Bread for the City of any changes that might affect the consumer's budget or benefits. Representative Payee services are also provided by several CSAs. This includes Anchor Mental Health, Community Connections and Psychiatric Services, Inc. (PSI).

My House Housing Mediation Services – DMH contracts with Advanced Dispute Resolution Services for mediation and dispute resolution services for consumers housed or eligible to be housed by DMH. DMH and CSAs can refer consumers for assistance with resolving pre-lease issues such as poor credit or criminal history, and for services to assist with landlord-tenant relations and facilitate conflict resolution to preserve tenancy and prevent eviction.

Supported Employment – DMH has expanded Supported Employment services throughout the system and funds six agencies to provide specialized Supported Employment Services to consumers for whom competitive employment has been interrupted or intermittent as a result of their mental illness. Services include ongoing work-based vocational assessments, job development, job placement and coaching, crisis intervention services, development of natural supports and follow-up for each consumer, including offering job placement that includes permanent employment.

4. Non-DMH Programs and Services

DHS PSHP Case Management – The Department of Human Services' (DHS) Permanent Supportive Housing Program (PSHP) is an initiative that provides permanent housing and supportive services to over 800 chronically homeless individuals and 250 families to ensure housing stabilization and self-sufficiency. Non-clinical case management services are provided to ensure that individuals and families are connected to needed support services and achieve the highest degree of stabilization and self-sufficiency possible. DHS PSH program participants also have access to move-in resources such as security deposits, gift cards to purchase home establishment items, and furniture. Mental health consumers who are chronically homeless and eligible for PSH according to a Vulnerability Assessment and other factors may gain access to this resource. DHS contracts with eight community providers, some of whom are also DMH-certified providers of MHRS services.

IV. Estimated Need for Affordable Housing for Persons with Serious Mental Illness Living within the District of Columbia

A. Methodology Used to Determine Need

TAC devised a methodology for DMH to project the need for both affordable and permanent supportive housing (PSH) among persons with serious mental illness (SMI) and serious and persistent mental illness (SPMI) living within the District of Columbia. People with disabilities including mental illness are overrepresented among those in poverty and have a need for affordable housing. To project this need, 2010 U.S. Census Bureau and Social Security Administration data were examined to obtain basic demographic, poverty, and Supplemental Security Income (SSI) utilization information. Prevalence estimates from DMH's most recent SAMHSA Block Grant application were then applied to project the District's adult population with mental illness living in poverty and therefore the supply of affordable housing that should be available.

Since not all people in need of affordable housing would necessarily choose to live in or meet the definition of being in need of PSH, the number of individuals with mental illness who have the unmet, highest priority need for PSH was also estimated. Included were: a) the number of non-elderly people with mental illness receiving SSI disability payments, which is considered a reliable proxy of the need for both public sector human services and affordable housing; and b) the number of homeless individuals with mental illness identified through the D.C. homeless Continuum of Care's (CoC) 2011 point-in-time (PIT) count who are likely not yet enrolled but qualified for SSI. This estimate was then applied to the number of consumers currently served in supportive housing and other residential programs to reach a projected need for DMH housing.

The 2010 Census, poverty, and SSI data examined is summarized in the tables that follow and indicate that 24,371 (4.05%) of D.C.'s total population receive SSI benefit payments, with the largest portion of these being disability-related payments. Of those under 65 receiving SSI, approximately 31% qualify due to a mental illness or other mental disorder not categorized as a developmental disability. However, it is difficult to separate out non-elderly adults in these figures as SSI data does not provide information on mental disorders for the under age 18 or aged 18-64 populations specific to D.C.

TABLE 3: DISTRICT OF COLUMBIA DEMOGRAPHIC CHARACTERISTICS & SSI UTILIZATION, 2010[15]

Population Category	District of Columbia	United States
Total population	601,723	308,745,538
Pop < 18	101,090 (16.8%)	74,098,929 (24%)
Pop 18-64	432,037 (71.8%)	194,509,689 (63%)
Pop 65+	68,596 (11.4%)	40,136,920 (13%)
Percent with disability	11.1%	11.9%
Total SSI	24,371 (4.05%)	7,912,266 (2.56%)
SSI-Disabled	22,354 (3.71%)	6,659,124 (2.16%)
SSI: under 65	20,182*	5,870,776
% Any Mental Disorder	64%	60%
% Mental Illness or non-MR Mental Disorder	31%	30%

[15] U.S. Census Bureau QuickFacts: http://quickfacts.census.gov/qfd/states/11000.html; *SSI Annual Statistical Supplement*, Social Security Administration, 2011.

* Includes 4,391 SSI recipients under the age of 18.

D.C. has the third highest poverty rate in the U.S., behind Mississippi and Louisiana. 2010 U.S. Census Bureau data indicates that nationally people with disabilities are overrepresented among those in poverty. In D.C., people on SSI comprise 20.35% of those in poverty.

TABLE 4: POVERTY[16] & SSI RATES IN THE DISTRICT OF COLUMBIA, 2010

Population Category	District of Columbia	United States
Poverty Rate	19.9%	15.1%
Number in Poverty	119,743	46,620,576
Total SSI	24,371	7,912,266
Percent SSI of Poverty	20.35%	16.97%

As shown in the next section, prevalence estimates from DMH's 2012 SAMHSA Block Grant application, displayed in **Table 5**, were applied to the data above in order to understand what portion of the adult population in poverty is likely to have a mental illness and be in need of affordable housing.

TABLE 5: DISTRICT OF COLUMBIA PREVALENCE ESTIMATES, 2010[17]

Population Category	DMH Estimated Number of Cases
People with Serious Mental Illness (6.10%)	27,889
People with Serious and Persistent Mental Illness (2.73%)	12,472
Total	**40,361**

B. Projected Need

TAC estimates that 8,797 people with mental illness within the District have a need for affordable housing based on the number of adults with SMI and SPMI who are in poverty as shown in **Table 6** below. Since many of these individuals may already be in some form of affordable housing, this figure represents an estimation of the supply of affordable housing that the District should have available to meet the needs of District residents with mental illness rather than unmet need.

TABLE 6: ESTIMATED NEED FOR AFFORDABLE HOUSING FOR PEOPLE WITH MENTAL ILLNESS

Poverty Population with MI	Estimate
Total Population	601,723
Population >18	500,633
Poverty Population (19.9%)	119,743
18+ Population in Poverty (83.2%)	99,625

[16] *Income, Poverty, and Health Insurance Coverage in the United States: 2010*. U.S. Census Bureau, 2011.
[17] Prevalence rates are from the most recent DMH SAMHSA Block Grant application. This includes those in institutions in group quarters.

18+ in Poverty with SMI (6.10%)	6,077
18+ in Poverty with SPMI (2.73%)	2,720
Total	**8,797**

To project the number of people with mental illness who have the highest priority, unmet need for PSH, the number of non-elderly adults with mental illness receiving SSI disability payments was estimated and added to the most recent CoC PIT estimate of the number of homeless individuals with mental illness as shown in **Table 7**. Based on this, 6,088 people with mental illness are projected to have the highest priority need and qualify for PSH.

TABLE 7: HIGHEST PRIORITY NEED FOR PSH

Population Category	Estimate
Total SSI	24,371
SSI 18-64	15,791
SSI <65	20,182
SSI<65 with MI	6,355
SSI 18-64 with MI*	**4,957**
PIT Homeless with MI	**1,131**
Total	**6,088**

* Removes 22% of the <65 SSI population under 18.

In order to project unmet need for DMH supportive housing and other residential program beds, the number of consumers currently served in supportive housing and other residential programs were considered. Data from the inventory of DMH and non-DMH housing resources summarized in **Table 8** shows an estimated 1,275 consumers are currently being served in DMH supportive housing. It also demonstrates that DMH consumers make up a portion of those housed in non-DMH supportive housing through local homeless programs including those operated through The Community Partnership (TCP) and the Department of Human Services' (DHS), as well as some community provider managed supportive housing. Since accurate estimates were not available regarding the number of homeless program units occupied by DMH consumers, both a high and low end estimate were determined. The high end estimate assumes the figure used by the U.S. Interagency Council on Homelessness that 60% of those who experience chronic homelessness have current or past mental illness. Since this figure may overestimate serious mental illness, a low end estimate based on the literature that demonstrates approximately one-third of those who are homeless have a serious mental illness is also used.

TABLE 8: CONSUMERS CURRENTLY SERVED IN DMH & NON-DMH SUPPORTIVE HOUSING PROGRAMS

Program	Numbers Served in PSH (High Estimate)	Numbers Served in PSH (Low Estimate)
DMH Supportive Housing Programs	**1,275**	**1,275**
Non-DMH Programs (Estimated % MI)		
DHS PSH (800)	480*	264**
TCP (1,650)	990*	544**
Provider Managed Housing	351	351
Total	**3,096 (high)**	**2,434 (low)**

* Based on USICH estimates that 60% of those who experience chronic homelessness have current or past mental illness.

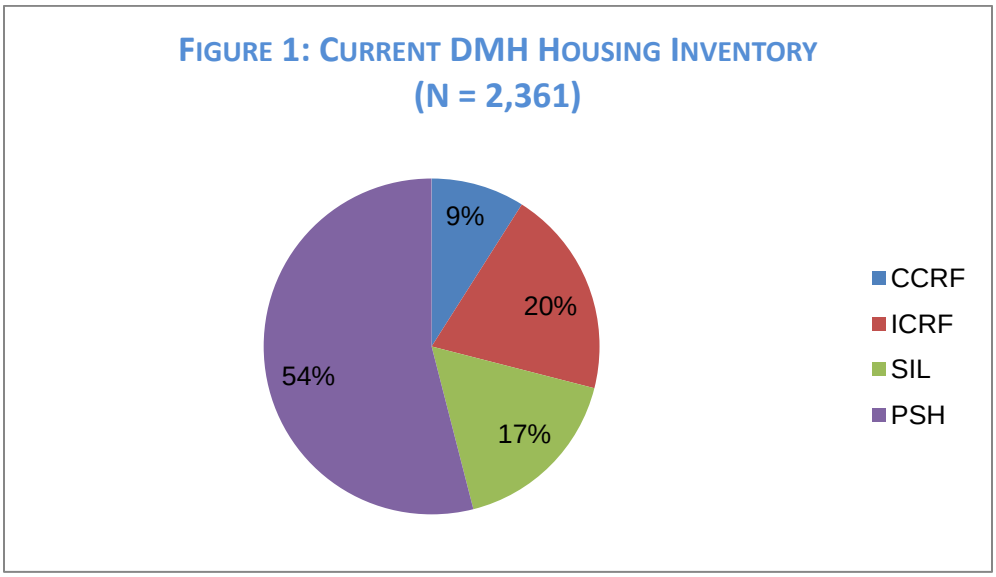
** Rather than use 60% estimate, a 33% estimate was used.

TABLE 9: UNMET NEEDS FOR BEDS

Need	6,088	6,088
Currently housed - PSH	-3,096	-2,434
Currently housed – DMH Other	-1,086	-1,086
Total Unmet Housing Need	**1,906 (low)**	**2,568 (high)**

Table 9 shows that adding the capacity of other DMH programs including C-CRF, I-CRF and SIL to serve 1,086 consumers, and subtracting those served in these and supportive housing programs from the projected need for PSH produces a low end estimate of unmet need for beds of 1,906 and a high end estimate of 2,568.

One of DMH's major goals is to increase the proportion of PSH within its housing inventory over the next several years. **Figure 1** below demonstrates the current breakdown, with PSH comprising just over half (54%) of the current DMH housing inventory, and can serve as a baseline for DMH to measure its progress in expanding PSH.



To begin to project need by DMH housing program type, need for additional PSH and for other housing settings should be estimated. The example presented in **Table 10** is for illustration purposes and may be adjusted based on more accurate estimates of the assumptions it presents. Using the current DMH supportive housing waiting list as a proxy for need, it was predicted that about 75% of the population in need could live in PSH based on the assumption that consumers with LOCUS scores of 1, 2, 3 and possibly 4 (with adequate support services) could live in PSH, and that the other 25% with LOCUS scores of 5, 6 and some with a 4 would need other settings. This does not account for consumer choice of housing setting which cannot be accurately predicted.

Based on assumptions regarding the proportion of those in DMH non-supportive housing settings who could move to PSH, percentages were applied to predict the numbers who could move requiring additional PSH units, and the numbers who would need to stay in their current housing thereby

preserving that bed capacity. It was estimated that 40% of individuals in C-CRFs, 50% of individuals in I-CRFs and 75-100% in SIL could move to PSH with appropriate supports. It should be noted here that the percentages applied are for illustration purposes and actual LOCUS score or other data for consumers in these settings can be applied to obtain more accurate figures.

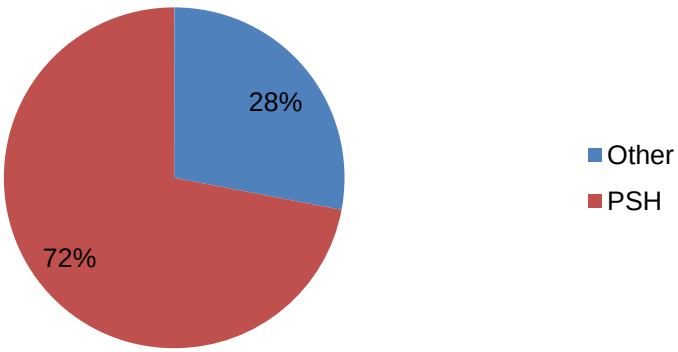
These assumptions are presented in **Table 10** and lead to the predicted need for 2,149 – 2,645 additional PSH slots and for a total of 844 – 1,009 other housing program beds.

TABLE 10: PROJECTED NEED BY HOUSING PROGRAM TYPE

Category	Projected Need for Additional PSH		Total Projected Need for Other Settings	
Unmet Need (1,906) or (2,568)	1,430 (75%)	1,926	477 (25%)	642
Served in CRF (221)	88 (40%)		133 (60%)	
Served in ICRF (468)	234 (50%)		234 (50%)	
Served in SIL (397)	397 (100%)		-	
Total	**2,149 (low)**	**2,645 (high)**	**844 (low)**	**1,009 (high)**

Over time this could result in PSH comprising nearly three-quarters of DMH's housing inventory, making it the Department's base housing model available to consumers.

FIGURE 2: PREDICTED DMH HOUSING INVENTORY



V. Strategic Goals and Findings

A wide range of topics were discussed with stakeholders, DMH staff, and other partners throughout this process. Similar to other mental health authorities across the country, DMH is tasked with broad responsibilities in managing the public mental health system with finite staffing and financial resources. As a result, DMH has identified six strategic goals over the next five years that form the Strategic

Supportive Housing Plan. These goals were formulated based upon the input received from stakeholders. A discussion of the findings and recommendations used to formulate each strategic goal is provided below, including the identification of areas of duplication, gaps in services, and unmet needs. A chart of actionionable implementation steps that will guide DMH follows each section. (**Appendix A** contains a consolidated chart of strategic goals.)

DMH has demonstrated significant leadership over the past several years dedicating substantial local resources for both capital financing and rental assistance in order to create over 2,400 permanent supportive housing (PSH) opportunities for DMH priority consumers. These efforts provide a solid foundation on which to build for future PSH efforts. Across Workgroups, there was agreement from members of the need for DMH leadership to provide clear, deliberate direction to the DMH provider community and its stakeholders regarding DMH's community-based housing efforts and priorities.

The Strategic Supportive Housing Plan is consistent with broader national efforts of: 1) promoting and advancing the civil rights of individuals with disabilities, consistent with the Americans with Disabilities Act (ADA) community integration goals affirmed in the U.S. Supreme Court's *Olmstead* decision, to enable individuals with disabilities to live in the least restrictive, most integrated settings possible; and 2) ending homelessness and chronic homelessness among people with disabilities. The Plan further builds upon DMH's existing Values[18] to promote the recovery of individuals through the availability of affordable housing coupled with an array of treatment, psychosocial rehabilitation, and peer specialist services, and strives to enable as many individuals as possible to live in Permanent Supportive Housing.

FIGURE 3: DEPARTMENT OF MENTAL HEALTH VALUES

Respect. All persons who come in contact with the public mental health care system are treated with dignity and valued for their abilities and contributions.

Accountability. DMH is responsible to consumers and family members for support and unobstructed access to services. The agency encourages all interested parties to participate in the planning, development, implementation, and monitoring of treatment, services, and policy.

Recovery. DMH services are provided based on the belief that people can recover from mental illness. Services and support for consumers and their families are tailored to:

- Empower them to improve their quality of life
- Address individual needs
- Focus on strengths and resiliency
- Provide choices and immediate access
- Provide opportunities to participate in rehabilitation, regardless of disability

Quality. The system is responsive, cost-effective, and incorporates high standards, best practices, cultural sensitivity, and consumer satisfaction. Service providers are committed to professional integrity, objectivity, fairness, and ethical business practices.

Education. DMH takes the following actions to improve the service delivery system:

- Shares information among consumers, family members, providers and the public
- Promotes prevention, wellness, and recovery
- Reduces stigma
- Recognizes the needs of others for information
- Communicates in an open and candid manner

Caring. DMH encourages genuine partnerships among consumers, family members, providers, and others that foster an unconditional positive regard for the concerns of those who seek and receive services.

DMH Webpage: http://www.dmh.dc.gov/dmh/cwp/view,a,3,q,515980,dmhNav,%7C31244%7C.asp

Goal One: Align District Policy and Improve Interagency Coordination in regards to Permanent Supportive Housing

Goal Formulation:

Create a District-wide Standard Permanent Supportive Housing (PSH) Policy

The District of Columbia has a strong track record of local investment in PSH development, particularly for tenant-based rental subsidies linked with appropriate supportive services assisting chronically homeless people. However, these investments are primarily project-by- project driven rather than directed by a comprehensive community-wide PSH policy – a circumstance not unique to D.C. DMH will work with all City agencies (DCHA, DHCD, DMH, DHS, DOA, DDS) involved in the development of permanent supportive housing (PSH) targeted for their priority consumer populations to adopt and incorporate a District-wide standard PSH policy and definition.[19] Through a standard D.C.-wide policy framework, the District will be able to better align and coordinate development, operating subsidies, and supportive services resources across the various District agencies.

District-wide Eligibility Criteria for PSH

Further, DMH will work closely with its fellow District Agencies (DCHA, DHCD, DMH, DHS, DOA, and DDS) to assess the feasibility of standard, basic eligibility criteria for all PSH throughout the District. The District could use this as baseline eligibility, and specific agencies may then have additional criteria depending on specific requirements. Consumers often enter the system through different portals overseen by various agencies, particularly DMH, DHS and DCHA. Sometimes this is by chance and sometimes it is because of how consumers have been directly or indirectly steered as a result of how various agencies structure their service delivery systems. This will ensure a simpler, more streamlined and navigable process for consumers and helping staff that tend to be heavily involved. Potential District-wide eligibility criteria could include:

a. Income Requirements: PSH is targeted to extremely low income households (30 percent of Area Median Income and below); and
b. Age: The PSH head of household is generally, but not exclusively 18-61 years old; and
c. Disability: A PSH household is a household in which a sole individual or an adult household member has a serious and long-term disability that:
    - Is expected to be long-continuing, or of indefinite duration;
    - Substantially impedes the individual's ability to live independently;
    - Could be improved by the provision of more suitable housing conditions; and
    - Is a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post traumatic stress disorder, or brain injury; is a developmental disability, as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 USC 15002); or is the disease of acquired immunodeficiency syndrome or any condition arising from the etiologic agency for acquired immunodeficiency syndrome.

Improve Interagency Coordination and Data Sharing with Regard to PSH

Through the workgroup process, key informant interviews and discussions with DMH staff, it was clear that planning and coordination between sister agencies could be improved. DMH will establish a DMH/DHS working group to streamline and better coordinate potentially duplicative or redundant services

[19] The SAMHSA definition described in Section V.B: Strategies Designed to Improve Service Delivery could be adopted by the District.

provided between DMH and DHS programs, with an emphasis on PSH settings. This group should meet regularly and have staff identified from each agency responsible to attend.

The development of a data sharing protocol between DMH, DHS, and DCHA would serve to compare and coordinate waitlist management activities. The purpose of this interagency effort would be to review and compare waitlists and active referrals; recommend transfer of individuals to another agency as appropriate; discuss and resolve current tenant issues as appropriate; and review application processes and paperwork in order to streamline access to services and housing for consumers and providers. TAC recommends that DMH and DHS use the lessons learned from the recent data sharing efforts between DMH and DHS/DCHA in regards to the award of new non-elderly disability housing vouchers to inform such efforts. Also, the DHS/DCHA real-time data sharing process may be a possible model for future DMH data sharing and data base development efforts. DMH intends to integrate this housing data sharing effort to the extent possible with DMH's ongoing database development project.

Coordinate Efforts with the DC Mayor's Office Integrated Case Management Initiative

The Mayor's office has initiated an Integrated Case Management Initiative designed to coordinate public benefits, services, and supports to individuals or families who display various risk factors across multiple District health and human service agencies. This may provide an additional opportunity to address the information sharing authorizations needed to readily share consumer housing information across agencies. Consumers served by DMH are frequently served by several agencies that manage distinct data sources, yet the information could be useful across agencies in order to improve efficiency and services for consumers. Given that DMH has experience navigating public benefits and entitlements, housing, primary healthcare and other systems, it is uniquely situated to inform data sharing processes, compliance with privacy laws, and ways to improve efficiency.

Goal One: Align District Policy and Improve Interagency Coordination in regards to Permanent Supportive Housing (PSH).			
Objective #1: Create a District-wide Standard Permanent Supportive Housing (PSH) Policy.			
Action:	**Responsibility:**	**Performance Criteria:**	**Timeframe:**
1. Convene District Agency partners (DMH, DCHA, HCD, DHS, DOA, and DDS) to develop a PSH policy to be adopted across all City agencies involved in the provision of PSH throughout the District. 2. Propose standardized District-wide eligibility criteria for PSH. 3. Incorporate the final District-wide PSH policy into each Agency's regulatory structure concerning PSH.	DMH, DCHA, HCD,DHS,DOA,DDS	1. Adoption of a permanent supportive housing policy across all City agencies. 2. Modifications of regulatory standards.	December 2012 Upon renewal of regulations.
Objective #2: Improve Interagency Coordination and Data Sharing with Regard to Permanent Supportive Housing (PSH).			
Action:	**Responsibility:**	**Performance Criteria:**	**Timeframe:**
1. Establish a DMH/DHS workgroup to streamline and better coordinate potentially duplicative or redundant services provided between DMH and DHS programs with an emphasis on PSH settings. 2. Develop a formal data sharing protocol between DMH, DHS and DCHA to compare and coordinate waitlist management activities. 3. Integrate this housing data sharing effort to the extent possible with DMH's ongoing database development project. 4. Develop a Memorandum of Understanding (MOU) between DMH and DHS which would formalize all efforts to coordinate the provision of PSH including data sharing protocols, waitlist management, and provision of supportive services. 5. Incorporate these formal data sharing protocols into the MOU between DMH and DCHA regarding PSH.	DMH and DHS	1. Establish Workgroup. 2. Adoption of data sharing protocol. 3. Establish MOU to coordinate PSH.	October 2012

Objective #3: Coordinate efforts with the DC Mayor's Office Integrated Case Management Initiative.			
Action:	**Responsibility:**	**Performance Criteria:**	**Timeframe:**
1. Participate fully in the Mayor's Office Integrated Case Management Initiative in order to improve communications and information sharing in regards to the provision of case management services to consumers residing in PSH. 2. Take the advantage of this effort to extent possible to assist in addressing the need for information sharing authorizations needed to readily share consumer housing and case management information across agencies.	Deputy Mayor for Health & Human Services	1. Establishment of communications and information sharing protocol.	To Be Determined

Goal Two: Develop a Pipeline to create 350-450 new permanent supportive housing (PSH) opportunities over the next 5 years for mental health consumers in need of PSH across the District.

Goal Formulation:

As mentioned previously, DMH has experienced a great degree of success in developing PSH across the District with a past emphasis on tenant-based opportunities. As a way to provide a broader balance of PSH available to priority consumers, DMH intends to develop and implement a Permanent Supportive Housing (PSH) Development Pipeline to create a range of 70 to 90 PSH units per year with a five year goal of 350 to 450 PSH units. DMH will also pursue reasonable set-asides of PSH units in multi-family housing developments (typically up to 25% of the units in a project) produced through Low Income Housing Tax Credit (LIHTC) and bond-financed properties. The primary driver of the PSH development pipeline will be the $5 million per year for the next five years (FY 2013-2017) of DMH Capital included in the District's Long-Term Capital Budget. Based on TAC's recommendations, DMH will incorporate the following approaches for the implementation of the Five Year PSH Development Pipeline.

Pursue a Streamlined Approach to Identify New Permanent Supportive Housing for DMH Capital Investment.

DMH will work to sustain and further develop the DHCD Consolidated and Comprehensive RFP processes as the mechanism to solicit and identify new PSH projects to invest in. As part of this process, DMH will continue its collaboration with DHCD in the underwriting and selection process of projects supported by DMH capital resources in order to create PSH that is consistent with DMH needs and model approaches. DMH should continue to maintain the right of 'final approval' of all projects to be supported with DMH capital resources. DMH Housing staff will continue to have direct involvement in the proposal review to ensure selected PSH projects are marketable and meet the needs of DMH consumers. PSH marketing considerations will include: location, affordability of rent, accessibility of community amenities and supportive services, and accessibility to public transportation.

DMH will collaborate with DHCD to conduct a marketing effort prior to the formal Request for Proposal process to better communicate the DMH Capital program to the District's developers of affordable, multi-family rental housing. The focus of this outreach should be on addressing barriers to participation and stressing the benefits of PSH. A marketing plan agenda may include topic areas such as the DMH referral and waiting list process, role of the supportive service provider, and role of the housing liaison.

Better Align Long-Term Operating Subsidies with the PSH Development Pipeline

DMH will work with its District Agency Partners, specifically D.C. Department of Housing and Community Development (DHCD), D.C. Housing Authority (DCHA) and D.C. Department of Human Services (DHS), to develop a process to program the required long-term operating resource commitments to annually support 70-90 PSH units for DMH consumers within the DHCD-sponsored Consolidated and Comprehensive RFP processes. This annual resource planning process of identifying operating subsidy commitments should consider all available operating resources to include the District's Local Rent Subsidy Program, the Section 811 PRA Demonstration, Section 8 Project-Based Vouchers (DCHA's Partnership Program), and DCHA's public housing operating subsidies. Additionally, DMH will take advantage of new federal funding resources as part of this process – specifically the HUD Section 811 project rental assistance (PRA) Demonstration Program.

The process would also seek to identify operating resource commitments for all the District's PSH priority populations to include people who experience chronic homelessness. The proposed resource planning process would transition an ad hoc, project-by-project resource discussion to a systematic process to identify and set aside operating resource commitments to support the District's annual PSH development goals. This systematic process will provide greater predictability for both District Agencies and its development partners. The process will also allow the Districts Agencies to better prioritize and control decisions and placement of scarce operating subsidies to support the District wide permanent supportive housing goals. The timing of this resource planning process should be aligned with both the District's budget cycle as well as the DHCD procurement process to incorporate all new operating subsidy resources that are available.

To support this annual planning process for operating subsidies, DMH will sustain a leadership role in the District's efforts to effectively compete for project-based rental assistance through HUD's Section 811 PRA Demonstration.[20] TAC estimates that the District could access project rental assistance for 60 to 80 PSH units to support the District's PSH pipeline over the next five years through this Demonstration program.

Establish a Capitalized Operating Reserve Pilot

As a complementary strategy to assist with identifying the needed operating subsidies for 70-90 PSH units annually, DMH will consider establishing a Capitalized Operating Reserve Pilot[21] funded with DMH Capital resources to support PSH units. Offering a pilot to support a limited number of PSH units (e.g. 20-30 units), DMH will be able to better test the viability and sustainability of the model with several D.C.-based developers of multi-family housing. The purpose of the Capitalized Operating Reserve Pilot would be to capitalize an operating reserve fund over a 10 to 15 year period in order to subsidize the difference between the operating cost of a one bedroom apartment in a multi-family housing project and the rental income which a disabled household with SSI income (approximately 11% of Area Median Income in the District of Columbia) can afford.

This is an approach already considered by D.C.-based developers. In the latest DHCD Multi-Family Request for Proposals (May/June, 2012), a well known D.C.-based developer, SOME, proposed this financing strategy as an alternative strategy to underwriting the long-term operating subsidies of its' PSH project, Altamont Place. This strategy was proposed as an alternative to the preferred approach of dedicating a long-term operating subsidy such as Section 8 Project-Based Vouchers to the PSH units. Moreover, TAC recommends that the DMH commitment of capital to fund a capitalized operating reserve for a PSH project should be made ***in lieu of*** a DMH capital commitment so as to not place an overly burdensome cost per unit on the DMH Capital Program. The Capitalized Operating Reserve Pilot could be highlighted as part of the District's upcoming Comprehensive Housing Strategy.

Figure 4 below presents an example of how a Capitalized Operating Reserve Pilot may be structured.

FIGURE 4: SAMPLE CAPITALIZED OPERATING RESERVE PILOT

Number of PSH Units. 20

Term of Pilot. 15 Years

D.C. Example.

Operating Cost Per Unit:	$7,088
Tenant Rent Share:	$2,512
Cost of the Operating Subsidy (Year 1):	$4,576
Required Operating Reserve (Per Unit/15 Yr Term):	$88,374
Required Operating Reserve (20 Units/15 Yr Term):	$1.76 million

Implement Permanent Supportive Housing Capacity Building Activities

Workgroup members suggested that there is a need for capacity building for those providers or developers interested in developing PSH. DMH will assist in linking its provider agencies that are either interested in PSH development or have some degree of experience and background with future capacity building and training opportunities. Specifically, DMH and its provider agencies will take full advantage of and maximize participation in the upcoming Corporation for Supportive Housing (CSH) Academy to build capacity and understanding of PSH development finance within the District's mission driven developer network. Recent projects such as Hyacinth's Place have indicated a need for technical assistance throughout the development of projects for new or less experienced developers.

Goal Two: Develop a Pipeline to create 350-450 new permanent supportive housing (PSH) opportunities over the next 5 years for mental health consumers in need of PSH across the District.			
Objective #1: Pursue a Streamlined Approach to identify new permanent supportive housing for DMH Capital Investment.			
Action:	**Responsibility:**	**Performance Criteria:**	**Timeframe:**
1. Utilize the DHCD Consolidated and Comprehensive RFP processes as the mechanism to solicit and identify new PSH projects. 2. Sustain close collaborative with DHCD on the review and approval of DMH Capital commitments to new PSH projects. 3. Collaborate with DHCD to conduct a marketing effort to attract new developers to participate in the DMH Capital Program. 4. Require routine process for reaching DMH's production goals.	DMH and DHCD	1. DMH part of RFP review process. 2. Develop marketing plan to attract developers to apply for DMH capital. 3. Development goals met annually and after 5 years.	Annual November 2012
Objective #2: Better Align Long-Term Operating Subsidies with the PSH Development Pipeline.			
Action:	**Responsibility:**	**Performance Criteria:**	**Timeframe:**
1. Develop/convene an annual resource planning process among District Agency partners to identify long-term operating subsidies to support a range of new PSH units to include the 70-90 PSH units created by the DMH Capital Program. 2. DMH will continue to play a leadership role in organizing District Agency partners to successfully compete for future operating subsidies made available through HUD's Section 811 PRA Demo Program.	DMH	1. Annual set-aside of long-term operating subsidies to support new development. 2. Submission of annual HUD Section 811 application, pending future NOFA from HUD.	Annual

Objective #3: Establish a Capital Operating Reserve Pilot.			
Action:	**Responsibility:**	**Performance Criteria:**	**Timeframe:**
1. Establish a workgroup comprised of DMH and DHCD staff to develop a plan to guide the establishment of a Capital Operating Reserve Pilot. 2. Identify a fiduciary agent to oversee/manage distribution from the capital operating reserve fund to the program sponsor. 3. Coordinate implementation of this pilot with the DC Affordable Housing Task Force to support further expansion. 4. Assess the pilot's success in order to inform plans to transition to a permanent program.	DMH and DHCD	1. DMH and DHCD workgroup established. 2. Implementation of Capital Operating Reserve Pilot. 3. Pilot evaluation	November 2012 Fiscal Year 2013 FY 2014
Objective #4: Implement Permanent Supportive Housing Capacity Building Activities.			
Action:	**Responsibility:**	**Performance Criteria:**	**Timeframe:**
1. Identify the specific training and capacity building needs around PSH development. 2. Coordinate the provision of training and capacity building activities with the Corporation for Supportive Housing's Training Academy.	DMH	1. Training module for PSH developers. 2. Included in CSH Training Academy	FY 2013

Goal Three: Maximize Existing PSH Resources to Meet the Needs of Mental Health Consumers Across the District.

Goal Formulation:

DMH has sponsored an impressive array of existing PSH opportunities throughout the District. TAC worked closely with DMH housing staff in the development of DMH's current permanent supportive housing (PSH) inventory, and estimates that there are approximately 2,434 existing PSH opportunities available to DMH consumers. Assuming that this PSH turns over conservatively at a rate of between 3-5% annually,[22] the existing PSH portfolio will generate an estimate of 80 - 134 PSH opportunities annually. To maximize existing PSH resources, DMH will implement strategies and protocols to effectively manage these existing PSH opportunities.

Focus Role of DMH Housing Staff

Given the importance that the Department places on PSH and the volume of PSH opportunities DMH has created, designated position(s) are needed to effectively manage, monitor and oversee the implementation of an expanding PSH program. Comparatively, DMH has more housing staff (six) than many larger state mental health authorities. This positive feature has enabled DMH to grow the supply of affordable housing for individuals with mental illness living in the District.

However, over time, absent clearly defined roles and responsibilities and the basic need to get the job done, the housing staff has assumed various housing responsibilities that should be managed at the provider level or by other District agencies. Moving forward, DMH intends to delegate more of these responsibilities (e.g. annual re-certification process, role in crisis intervention/landlord mediation of DMH consumers residing in permanent supportive housing) to the CSAs. As recommended elsewhere, Housing Liaisons can perform several of these tasks. DMH should assume a greater oversight role for the management, quality and performance of residential and supportive housing.[23] It is recommended that housing staff be re-tasked to perform these functions.

The housing office should be re-configured to do less direct consumer case management and more housing system management, including implementation of several recommendations in this report such as outcome development and monitoring. DMH housing staff plays an important role in the oversight and proper utilization of both DMH-sponsored housing resources as well as all other housing resources targeted to non-elderly people with disabilities. In this critical role, DMH Housing staff will focus its efforts on the following activities:

- Management of the waiting list for DMH-Sponsored Housing;
- Oversight of the PSH screening and certification process;
- Management of the DMH housing database and tracking system for DMH consumers;
- Implementation and management of an online Housing Resource Guide to assist DMH consumers and service providers in identifying an appropriate PSH opportunity;
- The consolidation and regular review/update of a comprehensive Memorandum of Understanding between DMH and DHCA to guide the effective management and targeting of special purpose housing vouchers including all Non-Elderly Disability vouchers (NED, Mainstream, Designated), Section 8 HCV set-asides (i.e. St. Elizabeth's Hospital and

[22] This is based on turnover rates in a sample of Public Housing programs.
[23] CSWs and Housing Liaisons at the provider level should be responsible for direct consumer-related service and housing work. DMH housing staff should only become involved in situations under emergent or extenuating circumstances.

Chronically Homeless), Section 8 PBV resources (the Partnership Program) supporting DMH-targeted PSH, and LRSP resources supporting DMH-targeted PSH;[24]
- Active participation in the DHCD project review process;
- Compliance oversight and coordination of the Housing Liaisons' role throughout the DMH system;
- Coordination of regular data sharing, and coordination with DHS and DHCA to ensure fair access of their housing opportunities;
- Compliance oversight to ensure DMH consumers are assessed on an ongoing basis to facilitate movement from transitional housing to permanent supportive housing; and
- Evaluation of outcomes across housing programs and informing program, clinical, and contracting staff regarding provider performance necessary for decision-making. Housing staff could also become part of provider and clinical site review teams.

Implement Home First 'Bridge' Rent Subsidy Program Enhancements

DMH will implement enhancements and changes to the structure of the Home First Rent Subsidy Program. As initially envisioned, the Home First Program was designed as a time-limited, tenant-based rent subsidy designed as a "bridge" to the Section 8 Housing Choice Voucher Program. Philosophically, the DMH Home First Program should not be seen as permanent rental assistance program. DMH acknowledges the realities of extremely long wait times on the Section 8 Housing Choice Voucher (HCV) Programs nationally including DCHA's program. However, DMH could gain significant benefits from implementing a series of enhancements to the Home First Program in order to strengthen the bridge to the Section 8 HCV Program, encouraging some level of flow from Home First to DCHA's federally-funded Section 8 HCV Program.

Most importantly, DMH will advocate with District and DCHA leadership to establish a set-aside within the District's Section 8 HCV program a defined number of vouchers for graduates of the Home First Bridge Subsidy Program. TAC recommends a reasonable set-aside of 50-60 Section 8 vouchers annually for graduates of DMH's Home First Program. Currently, DCHA's Section 8 HCV Program has three set-asides – chronically homeless households (447 vouchers), non-elderly disabled persons transitioning from St. Elizabeth's Hospital (50 vouchers), and individuals transitioning to independent living from a Long-Term Housing Settings (65 vouchers).[25] DCHA would establish this Section 8 HCV set-aside incrementally over time taking advantage of regular turnover within its Section 8 HCV program. The primary purpose of the set-aside is to create a small degree of 'flow' from the two programs on an annual basis.

In addition, DMH will consider the following enhancements to the Home First Program. DCHA is the current Administrator of the Home First Program. DMH will initiate conversations with DCHA to redefine the responsibilities of the Home First Subsidy Administrator to include all day-to-day administration of the rental subsidy program including the continuation of the annual and special re-certifications and managing rental payments to landlords. Alternatively, DMH may consider issuing a solicitation for this function to allow for consideration of other options. Within this process, DMH will also explore feasibility of creating a financial incentive within the subsidy administrator's fee structure to transition a specific number of DMH consumers to the Section 8 HCV program annually.

[24] In TAC's environmental scan, TAC identified two Memorandums of Agreement between DMH and DCHA from 1999 and 2004 concerning the agencies' collaboration on the administration of Mainstream Vouchers for people with disabilities respectively These agreements are in addition to the contract between DCHA and DMH to administer the Home First Rent Subsidy Program.

[25] TAC's Section 8 Made Simple Guidebook (2nd Edition, June 2003) highlights a PHA's discretionary authority to establish a "needs based" preference or set-aside within their Section 8 Housing Choice Voucher Program.

DMH will also seek to improve linkages and communication protocols between DMH Housing Staff and the DCHA staff managing the Section 8 HCV Program. For example, DHCA staff could provide DMH Housing staff and its provider agency network with early notification that the Section 8 Waiting List will be open at a specific time giving DMH and its provider adequate time to mobilize and prepare the Home First voucher holders to apply for entry to the Section 8 waiting list. In addition, DMH and DCHA should establish standard protocols that DCHA shall notify DMH Housing staff (in addition to the DMH consumer) of any requests for information to stay on the DCHA Section 8 Waiting List. This would ensure that DMH consumers receive the support needed to submit information in a timely manner to maintain their place on the waiting list.

In order to strengthen linkages with the Section 8 HCV Program, DMH will amend Chapter 22, Title 22-A 52 DCR 7026 for supported housing to: 1) formally require all Home First participants to apply for the DCHA Section 8 HCV Program (at the earliest possible time) as a condition of entry; and 2) formally require that the Home First participant agree up front as a condition of entry into the program to transition to a Section 8 voucher or similar type of rental subsidy if offered. Failure to accept the permanent rental subsidy is grounds for termination of assistance. In addition, DMH should consider defining an eligible household and the process to determine the bedroom size that the household is qualified for under the Home First Program. All program requirements should generally mirror requirements set forth by DCHA's Section 8 HCV program.

Several stakeholders also suggested that DMH increase the Home First contract rent to 100% of Fair Market Rent (FMR) to better align the Home First Program with the Section 8 HCV policies as well as provide the Home First participant greater 'buying power' and choice in identifying a rental unit in a broader selection of neighborhoods throughout the District. Absent new funding to pay for this change, DMH will need to consider the effect of fewer consumers being served against the potential benefits of offering more choice of housing based on increased rental subsidies. [26] Alternatively, DMH will consider setting the contract rent for the Home First Program to the 80% of the current year's FMR in order to keep pace with the current rental market in the District. Currently, the contract rent is set at 80% of the 2011 FMR and does not change annually. This type of policy change would require modest budget growth annually in order to implement successfully.

Over the long-term, DMH will assess with DHS the feasibility of combining the Home First Rent Subsidy Program and DHS's PSH Program. A merger of these District-funded rental assistance programs would likely lead to greater efficiencies in the staffing model, streamlined/combined program regulation for both subsidy streams, and a consolidated waiting list. Given these potential benefits, TAC recommends further discussion between the two agencies and possibly a formal assessment further exploring the benefits and policy trade-offs from such a merger.

Expand and Enhance the Housing Liaison Position

The six existing Housing Liaisons play a critical role in supporting the provision of PSH and supporting successful tenancy. Recognizing their benefit, as well as acknowledging the need to devolve some consumer-level responsibilities from the DMH Housing staff as discussed earlier, DMH will explore ways to support the expansion of Housing Liaisons to support all Core Service Agencies (CSAs) throughout system. As part of this expansion, DMH will standardize the role and functions of the Housing Liaisons across the CSAs, including a reasonable caseload size. To promote consistency and competency, DMH

[26] TAC estimates that DMH will be able to serve approximately 162 less DMH consumers through the Home first Program if the contract rent limit was raised to 100% of FMR.

will support an ongoing training and capacity building program for the Housing Liaisons. Finally, DMH may consider a certification initiative for the Housing Liaison role.

Since most functions performed by Housing Liaisons are not reimbursable through MHRS, there is currently no funding mechanism to support these positions. DMH will need to identify a funding source to support these positions.

Develop and Manage an On-line Housing Resource Guide

Workgroup members stated that CSWs and consumers are often confused about the requirements for and availability of various housing resources. As a mechanism to maximize the use of existing PSH opportunities throughout the system, DMH will develop and maintain an online Housing Resource Guide to provide consistent and up-to-date information on all housing programs to facilitate system-wide understanding of resources and effective, efficient referrals. The Housing Resource Guide will include: a description of each housing program (Home First, LRSP, DHS PSHP, Continuum of Care funded housing for the homeless, etc.), and real time information on the availability, eligibility criteria, requirements and applications procedures for all housing opportunities available to DMH consumers across the District. The purpose of the Housing Resource Guide is to streamline and facilitate the application process, increase availability and accuracy of information on housing opportunities across the system, and improve transparency and information sharing across the DMH provider network. DMH should coordinate online Housing Resource Guide development efforts with The Community Partnership and the District's Interagency Council on Ending Homelessness.

Sustain DMH Capital Support (HIPi Program) to Preserve Existing DMH-sponsored PSH

Providing capital funds to preserve existing DMH sponsored housing was noted to be important, and TAC supports DMH's current efforts to offer capital funds through the Housing Improvement Program initiative (HIPi)[27] to rehabilitate and preserve existing DMH sponsored housing. In the future, DMH will focus its preservation resources primarily on sustaining the permanent supportive housing portfolio. Over the next 5-10 years, preservation activities will become an increasingly important element of DMH Housing Program activities as existing PSH (10-15 years of operation) could be in need of a moderate rehabilitation. Over this period, DMH will consider utilizing the HIPi Program to assist PSH owners in sustaining the housing stock as well as leverage both private and public capital resources.[28] DMH will also continue to pursue efforts to utilize the HIPi Program to address accessibility needs on the first Floor of DMH sponsored residential programs including permanent supportive housing.

[27] The HIPi Program is a program administered by Cornerstone through a grant of $1 million through the DC Department of Community Development. These funds are appropriated capital funds from the DC Department of Mental Health.
[28] To the extent possible, DMH should require that all PSH development build in operating reserves sufficient to prepare for and pay for all necessary repair, maintenance and capital expenses.

Goal Three: Maximize Existing PSH Resources to Meet the needs of Mental Health Consumers Across the District.			
Objective #1: Focus Role of DMH Housing Staff.			
Action:	**Responsibility:**	**Performance Criteria:**	**Timeframe:**
1. Redefine the roles and responsibilities of the DMH Housing Staff focusing on the broader role of housing systems management. 2. Shift direct DMH consumer support on housing matters to the DMH-sponsored Housing Liaisons consistent with expansion of this program.	DMH	1. DMH should develop an Office of Housing scope of work as well as individual job descriptions.	December 2012
Objective #2: Implement Home First 'Bridge' Rent Subsidies Program Enhancements.			
Action:	**Responsibility:**	**Performance Criteria:**	Timeframe:
1. Advocate with both Mayor's Office and DCHA Leadership to establish a set-aside within the District's Section 8 HCV Program of a defined number of vouchers for graduates of the Home First Subsidy Program. 2. Redefine the roles and responsibilities of the Subsidy Administrator that manages the Home First Subsidy Program. 3. Establish more formal linkages and communications protocol between DMH Housing Staff and DCHA staff, to be memorialized in an updated Memorandum of Understanding between the two agencies. 4. Amend the DMH Supportive Housing Program Regulations in Chapter 22, Title 22-A 52 DCR 7026 to generally mirror the requirements set forth in DCHA's Section 8 HCV program. 5. Assess the feasibility of establishing the Home First Contract Rent at 100% of Fair Market Rent (FMR). 6. DMH and DHS jointly assess the feasibility of	DMH	1. Set-aside of Section 8 HCV's for graduates of Home First Subsidy. 2. Revised MOU between DMH and DCHA. 3. Amended DMH PSH regulations to be more consistent with DCHA Section 8 HCV program.	Fiscal Year 2013

combining the Home First Subsidy Program and the DHS PSH Program.			
Objective #3: Expand and Enhance the Housing Liaison Position to Provide Adequate Coverage Throughout the District.			
Action:	**Responsibility:**	**Performance Criteria:**	**Timeframe:**
1. Expand the number of housing liaison positions to provide adequate coverage. 2. Formalize the roles and responsibilities of the Housing Liaison within the DMH system. 3. Devolve the responsibilities of direct DMH consumer support on housing matters from the DMH Housing Staff to the Housing Liaisons as part of this effort. 4. Provide on-going training and capacity building support to the Housing Liaisons in order to promote consistency and competency. 5. Consider a certificate program for the Housing Liaisons modeled after the DMH's Community Support Workers Certification Program.	DMH	1. Define role of Housing Liaison. 2. Incorporate role of Housing Liaison into regulation. 3. Identify funding source to procure additional Housing Liaison positions. 4. Development of training module for Housing Liaisons.	Fiscal Year 2013
Objective #4: Develop and Manage an Online Housing Resource Guide on PSH Opportunities Within the District.			
Action:	**Responsibility:**	**Performance Criteria:**	**Timeframe:**
1. Establish a DMH-led workgroup to develop an implementation plan to guide the development of an online Housing Resource Guide. 2. Coordinate implementation efforts with all District Partners to ensure DMH's efforts are aligned properly with other PSH information sharing efforts as well as reduce the risk of duplication of effort among District Partners.	DMH	1. DMH Workgroup to guide development of Housing Resource Guide (HRG). 2. Completion of on-line HRG, incorporating it as part of the DMH website.	January 2013 June 2013

Goal Four: Restructure DMH Residential and Housing Programs into Two Primary Program Models - Permanent Supportive Housing and Transitional Residential Services

Goal Formulation:

Approach to Residentially-based Services

Over time, many mental health systems have built discreet programs designed to meet varying ***levels*** of need. However, systems with multiple programs tend to be rigid and inflexible to meet consumers' dynamic needs, and result in being bound by the requirements within the program. Rather than focus on levels of service by program, DMH intends to organize the current continuum of residential programs into ***Transitional Housing Services*** and ***Permanent Supportive Housing*** in order to clearly articulate the purpose of housing support services in the District. This will enable DMH to deliver or wrap services around individuals based upon their changing needs rather than by the program they are in.

Standard Permanent Supportive Housing (PSH) Definition

Absent a clear definition of permanent supportive housing (PSH), the implementation of PSH in the District is loosely defined. In order to ensure consistent implementation of PSH services, DMH will establish and adopt a standard PSH definition and principles to guide the creation and management of all PSH sponsored by the Department. The following principles outlined in the SAMSHA PSH Evidence-Based Practice KIT shall serve as a guide:

- PSH is permanent, community-based housing targeted to extremely low income households with serious and long-term disabilities;
- PSH tenants have leases that provide them with all rights under tenant-landlord laws. Generally, PSH provides for continued occupancy with an indefinite length of stay as long as the PSH tenant complies with lease requirements;
- At a minimum, PSH meets federal Housing Quality Standards (HQS) for safety, security and housing/neighborhood conditions;
- PSH complies with federal housing affordability guidelines – meaning that PSH tenants should pay no more than 30-40 percent of their monthly income for housing costs (i.e., rent and tenant-paid utilities);
- PSH services are voluntary and cannot be mandated as a condition of admission to housing or of ongoing tenancy. PSH tenants are provided access to a comprehensive and flexible array of voluntary services and supports responsive to their needs, accessible where the tenant lives if necessary, and designed to obtain and maintain housing stability;
- PSH services and supports should be individually tailored, flexible, accessible by the tenant, and provided to the extent possible within a coordinated case plan;
- PSH provides a level of choice of unit in response to consumer preferences;
- Variety and range of PSH models - best-practice PSH approaches include a variety of evidenced-based, flexible models to include tenant-based and project-based initiatives. Successful approaches in other communities include the cross-disability model, small set-asides of PSH units in multi-family housing developments produced through Low Income Housing Tax Credit (LIHTC) and bond-financed properties, as well as the single purpose single population PSH model; and
- As an evidence-based practice, the success of PSH depends on ongoing collaboration between service providers, property managers, and tenants to preserve tenancy and resolve crisis situations that may arise.

Permanent Supportive Housing Eligibility and Allocation Criteria

As DMH moves toward a PSH-based system, it will be important for DMH to develop and adopt a set of standardized eligibility criteria in order to manage access to DMH-controlled permanent supportive housing opportunities for priority populations as effectively as possible. Based on feedback from stakeholders, DMH will develop and incorporate the following PSH eligibility criteria:

- Screening and Certification Process
- Basic Eligibility for DMH Priority Populations
- System-wide Allocation Process

Below is a detailed discussion of these elements:

1. Standard PSH Screening and Certification Process:

A concern raised by workgroup members was that eligibility determinations by agency could result in inconsistencies and inequitable access to PSH, and that a standardized, initial PSH Eligibility Determination questionnaire should be developed that can be used by all DMH contract agencies that come in contact with individuals who may need PSH to determine initial eligibility. The screening form should obtain information regarding whether the person needs services only and/or rental assistance, as well as information that may also be used by other agencies, like DHS, to satisfy their requirements for housing assistance that the person may eligible for.[29] To the extent possible, DMH Housing staff should manage this process electronically through a web-based system so that information from multiple agencies is entered into a consolidated planning list.[30] DMH Housing staff intends to certify eligibility and authorize a process whereby a consumer accesses PSH or is placed on a planning/waitlist.

2. PSH Eligibility for DMH Population:

Despite finite resources, basic eligibility criteria should be flexible enough to include consumers with serious mental illness with a range of needs. As a result, DMH intends to implement the following basic eligibility criteria:

a. Income Requirements:[31] PSH is targeted to extremely low income households (30 percent of Area Median Income and below); and
b. Age: The PSH head of household is generally, but not exclusively 18-61 years old;
c. Disability: A member of the household has a serious mental illness that qualifies them for Medicaid-funded or other funded supports and services operated by the Department of Mental Health; and
d. Qualify as 'In Need of PSH': A person shall be considered to be 'in need of permanent supportive housing' if a person has a serious mental illness that is expected to be of long, continued or indefinite duration; substantially impedes their ability to live independently without supports; and is of such nature that such ability could be improved by more suitable housing conditions.

3. DMH PSH Allocation Process:

[29] DMH would need to establish requirements to safeguard protected information.
[30] Community agency staff may initially take the information on a hard copy that can be entered electronically later.
[31] These criteria reflect the need for both services and subsidized housing. For individuals who already have access to subsidized housing, income requirements used to determine eligibility for Home First rental assistance would not apply.

DMH will implement a process to allocate resources to those who meet basic eligibility criteria for PSH for DMH controlled PSH resources. This process should balance the need to target resources to priority populations, but also be flexible enough to include those who develop or present with extenuating circumstances. DMH intends to allocate PSH based on a process that considers the following criteria:

a. Whether the consumer meets the general eligibility criteria above;
b. Whether the consumer is considered one of the three priority populations (i.e. Discharge from Saint Elizabeth's, homeless, or moving to less restrictive setting), or;
c. Whether an exception to the priority population criteria is justified based upon extenuating circumstances, such as an emergent housing crisis or specialized need for PSH.

Supported Independent Living (SIL) Program

As part of this process, TAC began an initial evaluation of the Supported Independent Living (SIL) Program. It was clear that services provided in SIL support consumers with a variety of needs. However, there is variability in how the program is operated throughout the system with models ranging from traditional continuum congregate residential programs (with the only difference being less than 24/7 on-site staffing), to housing and services aligned with principles and practices of permanent supportive housing. In addition, there was variability in how funds are used to support the programs. As DMH moves to a model of Permanent Supportive Housing and Transitional Residential Services, SIL will need to be reorganized to be consistent with this approach.

Appendix F has more detailed discussion about the Supported Independent Living (SIL) Program.

Contracted Community Residential Facilities (C-CRF)

In April 2010, DMH established the Community Residential Facility (CRF) Task Force that resulted in a pilot to re-balance CCRFs so that individuals could transition to PSH settings and others with higher needs in ICRF settings could gain access to CCRFs. This pilot is an opportunity to better assess, plan for, and provide linkages to services based on individual need so the system can wrap the right services around individuals, regardless of setting, and develop clear transition plans for consumers who want to move to supportive housing. It may also help to ensure flexible housing and service options for consumers with more challenging short or long-term needs (e.g., medically fragile, forensics, transition age youth).

As part of this initiative, DMH desires to reduce CCRF beds from 225 to 150 while preserving availability of more supervised services for those with higher needs. The dollars saved by decreasing the number of Contract CRF slots will be used to increase the current number of housing subsidies available to consumers in need of affordable housing and to develop a 'flexible funding pool' to fund non-Medicaid billable services and supports required to assist consumers in CRFs to maintain their community tenure.

DMH is cognizant that there are consumers in the system with complex needs that may benefit from CCRF level of services, such as those who are transition-age youth, older adults, forensically-involved or have co-occurring disorders. As DMH re-balances CCRFs and PSH resources, it must also continue to assess the need for CCRF's and other program models and develop clear strategies to provide supportive housing opportunities to these populations.

Appendix G has more detailed discussion about Contracted Community Residential Facilities.

Revise Regulation and Contract Requirements to Align with and Articulate New Models

DMH will utilize regulations and contract requirements as a framework to institute many of these changes, with caution exercised so that over-regulation does not become an unintended consequence.

As discussed above, DMH will organize regulations into ***"Transitional Residential Services"*** (i.e. for C-CRF, and transitional services, components of SIL) and ***"Permanent Supportive Housing"*** for supportive housing and independent housing-related services. Establishing standards for Transitional Housing Services and Permanent Supportive Housing will provide DMH the ability to establish minimum expectations, infuse performance measures, and ensure consistency of services across the system.

Standards for services delivered in Permanent Supportive Housing will be organized into Chapter 22, Title 22-A 52 DCR 7026 regulations for supported housing. PSH services should delineate: 1) the services that are available within the community to individuals living in PSH or other community settings; and 2) need and eligibility for Housing Assistance (i.e. Home First rental subsidy, deposits, etc.). Regulations related to PSH should discuss what is expected to be provided, consistent with MHRS, be aligned with PSH principles and definition, and include requirements for delivery of best practice services and outcomes.

In ***Transitional Residential Services***, it is important to state that the purpose of program(s) is intended to be transitional and to prepare individuals to move to PSH or independent living. Regulations and contract requirements should incorporate the expectation that all residents of C-CRF, I-CRF and SIL have, as part of their Individual Recovery Plan, a goal of PSH or other more independent living setting.

Regulations and contract requirements will stipulate the development of a specific Transition Plan, incorporated into the IRP/IPC to support the move to PSH or independent housing. All individuals approved for PSH will have as part of his/her overall service plan an initial transition plan that specifies the activities, roles, and responsibilities to support the person during pre-tenancy and initial move in, including the use of Peer Support Specialists. This plan will be developed with the individual, staff from existing setting (Saint Elizabeth's, CRF, SIL, CTI, etc), and the CSA staff who will support the person once in PSH. While it is not necessary to use a formal CTI process, concepts from that model should be used to ensure seamless and coordination of services and supports. DMH may want to review outcome data for people who have failed during transition and review what supports could have been put in place.

In both Transitional Residential Services and PSH services regulations, DMH will establish a more detailed quality improvement process that defines the activities that providers should adhere to and outlines the roles and responsibilities that DMH will engage in from a quality oversight perspective.

DMH will also consider incorporating and implementing other evidence-based practices, including Illness Management and Recovery and Motivational Interviewing/Enhancement techniques, especially in the C-CRFs, to promote transition to PSH and other independent settings.

Goal Four: Restructure DMH Residential and Housing Programs into Two Primary Program Models - Permanent Supportive Housing (PSH) and Transitional Residential Services (TRS)			
Objective #1: Revise regulations and Program Rules to Align with and Articulate New Program Models.			
Action:	**Responsibility:**	**Performance Criteria:**	**Timeframe:**
1. Establish DMH workgroup to develop regulatory standards for PSH and TRS. For PSH, workgroup should define and adopt definitions for TRS and PSH (based on SAMHSA definition), and include purpose, priority populations, eligibility, intended consumer outcomes, services, facility/site considerations, staffing, etc.	DMH	1a. Key DMH staff identified for membership for regulation revision workgroup, chair or co-chairs selected and first meeting scheduled 1b. Standards drafted for PSH and TRS program models and review by DMH executive leadership 1c. Standards for PSH and TRS program models finalized and ready for submission	December 2012 February 2013 March 2012
2. Publish standards for public comment, make revisions as necessary and adopt.	DMH	2a. Standards submitted and published for public comment 2b. Final standards published and adopted. DMH develops Implementation Plan	March 2013 May 2013
Objective #2: Reclassify Existing SIL programs into one of the New Program Models (PSH or TRS) Based on DMH Needs and Current Operations.			
Action:	**Responsibility:**	**Performance Criteria:**	**Timeframe:**
1. DMH will evaluate how SIL can be incorporated into PSH and TRS services.	DMH	1. Each SIL program will be designated as either PSH or TRS based on proposed standards.	September 2012
2. DMH will re-evaluate its use of funding associated with SIL, and more clearly identify how funds should be used.	DMH, includes meetings with SIL providers	2a. DMH completes assessment of impact on program operations if SIL funding is reduced to housing related costs only or eliminated all together. 2b. Budgets developed for each SIL program	September 2012 October 2012

3. DMH will require each SIL provider to submit a plan to re-align its existing program model with the DMH-desired model, including timeframes and specific changes to program operations.	DMH, SIL providers	reflecting total operation costs as new program designation (PSH or TRS). 2c. Based on operating costs of SIL programs when operating under new model, DMH will decide on reallocation of any available SIL funds 3. Plans submitted by providers detailing transition process and timeframe to be fully operational as new program model (PSH or TRS)	October 2012 October 2012
Objective #3: Use procurement and Contracting Process to Align Existing Programs with New Models, Set Performance Expectations and Budget			
Action:	**Responsibility:**	**Performance Criteria:**	**Timeframe:**
1. DMH will assess the need for C-CRF beds for emerging populations (i.e. transition-age youth, older adults, forensically-involved, co-occurring disorders). 2. DMH will target TRS beds (formerly C-CRF) for prioritized emerging populations and reduce the number of C-CRF beds to be replaced in the system by PSH slots. DMH will use contracting and procurement processes to transition existing C-CRF consumers to PSH units. As individuals move to PSH, DMH will take C-CRF bed off-line.	DMH DMH	1. Assessment summary of priority emerging populations and estimated need for C-CRF (TRS) bed. 2. Draft RFP or RLI for transitioning current C-CRF consumers to PSH and converting identified beds to TRS for prioritized emerging population.	October 2012 October 2012

Goal Five: DMH will improve the quality of services delivered in PSH.

Goal Formulation:

While increasing and maximizing the supply of affordable housing is important to supporting individuals in integrated, community-based settings, the quality of services delivered to consumers is critical to their readiness for independent living and community tenure. Some of the areas identified as challenges include the need to utilize outcome measures to drive system quality and accountability, clearly articulated roles and responsibilites, minimize redundancy across provider systems, and ensure the delivery of best practice services, including care coordination.

Develop and Implement Outcome/Performance Measures

DMH will establish system-wide outcomes related to PSH and Transitional Residential Services programs, and incorporate performance into decision-making. By proactively developing a set of performance measures specific to housing and housing supports, DMH can evaluate consumer-level outcomes, provider performance, and program model performance. More specifically, DMH may begin to more proactively improve residentially-based program models or favor some models based upon outcome evaluation.

DMH collects a significant amount of data from providers through its electronic consumer management and billing system, known as eCura, as well as housing information gleaned from various documentation sources. However, this information is not coordinated, and DMH housing staff must extract data from eCura and upload it into a housing database for housing management purposes. It is recommended that DMH Housing staff be provided with access to a data base that allows them to collect, track and analyze housing related data that can be used for quality improvement, monitoring and oversight. DMH is in the process of implementing a more comprehensive system that better coordinates information and is more user-friendly and accessible to DMH staff and the provider community. This will be an important tool for DMH once implemented.

Nevertheless, DMH will adopt and initiate various performance measures specific to housing and housing supports now that can be built into the new system once developed. DMH currently evaluates various indicators throughout the system to understand program and consumer level outcomes, but outcome measures in the context of housing could be incorporated to assess whether housing and/or the quality of housing and the housing model have had a positive or negative impact on an individual consumer.

For example, as part of the SAMHSA Block Grant National Outcomes Measures (NOMS), DMH collects, through the MHSIP survey, various measures. For example, one goal is to increase the social supports and social connectedness of individuals. DMH will consider refining this measure to evaluate an individual's social connectedness depending on the type of housing they are in, and/or the quality of the program. Another goal for which data is collected concerns improving an individuals' level of functioning. Similarly, DMH will evaluate the degree of progress individuals make depending on access to housing, type of housing or the provider operating the housing.

Examples of process measures that DMH will consider include various recommendations in this report, such as revisions to regulations; evaluation and modifications to SIL; the implementation of training modules in the Learning Management System; revising the roles of DMH housing staff; and improving the proportion of PSH compared to C-CRFs. DMH will also consider adopting and evaluating outcome measures such as a person's health status, employment, personal relationships, community inclusion, self-determination, and choice, using access to housing and housing supports as variables. As part of this

process, DMH will refer to the Substance Abuse Mental Health Services Administration's (SAMHSA) National Outcomes Measures[32] and the National Core Indicators[33] for more information.

In addition to the redefined roles identified in Goal Three for the DMH Housing Staff, if new outcome measures specific to housing are developed and there is greater attention to quality oversight of housing providers, DMH housing staff are uniquely positioned to assume these roles, especially in coordination with the Department's Applied Research and Evaluation Unit (ARE). This could include evaluating outcomes across housing programs and informing program, clinical and contracting staff regarding provider performance necessary for decision-making. It also could involve designated housing staff becoming part of provider and clinical site review teams.

Improve Provider Performance and Accountability

As DMH moves toward a more performance-based system, it will review its requirements for CSAs and ensure they are providing the proper case management for individuals, including for those who are difficult to engage or are treatment resistant. DMH will establish a review process/function to ensure that providers are held to standards and that quality, best practice services are being delivered to consumers and worked into service plans. Individual service plans should have a housing component built in with clearly identified responsibilities (i.e. securing apartments, skill training for housing-related tasks, contacts with landlords). As discussed above, these requirements will be incorporated into regulation and contracts.

Good care coordination can ensure the availability of flexible, responsive wrap-around supports needed to promote tenure over time. Because individuals have complex needs, they frequently receive more than one service from more than one program; sometimes these programs are operated by different agencies and funded by different government agencies (e.g., DMH, DHS, and DCHA). CSAs play a role of coordinating services for individuals, but there is inconsistency in how care is coordinated, who's accountable, and the roles and responsibilities of providers in each person's care. DMH will clearly define the role of care coordination, incorporate it into regulation and hold providers accountable to the role. This does not suggest additional staffing, but rather clearly articulating the basic roles and responsibilities for direct care staff that function in the role of 'care coordinator' in each individual's Individual Recovery Plan/Individualized Plan of Care (IRP/IPC). DMH will apply this across the system so that there is a basic expectation of consistent care coordination for every individual. For individuals who are involved in DMH services and DHS case management, this will serve to minimize the redundancy and confusion around roles and responsibilities.

However, non-billable service coordination was identified as a challenge, and there is a real need for funding flexibility to provide this service. While MHRS offers a good set of clinical services for DMH consumers living in supportive housing, providers still struggle with the flexibility of MHRS to keep people in housing, with community support offering the least flexibility and ACT being more flexible. Opportunity exists to enhance care coordination by assigning responsibility and ensuring accountability across Core Service Agencies (CSAs) for DMH consumers in housing settings, particularly when a consumer is involved with more than one provider. This will help to minimize potential duplication of services as well.

Increase the Supply of Peer Support Specialists Working in Community Programs

Peer Support Specialists are increasingly well-received in the District. The role of Peer Support Specialists during the transition process is valuable and could be expanded to all consumers transitioning

[32] SAMHSA NOMS: http://integratedrecovery.org/wp-content/uploads/2010/08/SAMHSA-National-Outcome-Measures.pdf
[33] http://www.nationalcoreindicators.org/resources/guides/

to community living and extended throughout tenancy. By increasing the frequency and number of trainings, DMH will increase the supply of certified Peer Support Specialists available to work in PSH, hospital, and transitional residential settings.

DMH will need to explore flexible funding mechanisms in order to increase the supply of Peer Support Specialists working in community programs. Many services provided by Peer Support Specialists are Medicaid reimbursable, and DMH has recently developed a mechanism that reimburses DMH certified peer specialists through MHRS. In addition, DMH will explore non-Medicaid funding sources to support important, yet non-billable, services.

Improve Overall Engagement and Retention

Occasionally, consumers reject PSH services once they access affordable housing, and providers become concerned about consumer well-being and their own liability. A combination of workforce training specifically related to engagement strategies (See Goal Six for workforce and training), clearly defined program requirements upon admission, and transition to other rental assistance resources can improve overall engagement and retention.

As an engagement strategy, DMH could consider requirement of consumer agreement to minimum of one contact per month by CSW. While the individual may still terminate or refuse services, s/he will have been told upfront that staff will continue to engage, outreach and contact.

In addition, DMH could expand the Monthly Visit Report that is currently used to include more than just unit inspection. Or, create a similar monthly report that the CSW is to complete beyond any case notes as required by MHRS. This recommendation is based on consistent concerns expressed in workgroups and by Property Managers that CSW visits to consumers are inconsistent. Where they exist, the Housing Liaison completes this form currently (hence its focus on inspection of unit).

Goal Five: DMH will Improve the Quality of Services Delivered in PSH			
Objective #1: Develop and Implement Outcome/Performance Measures			
Action:	**Responsibility:**	**Performance Criteria:**	**Timeframe:**
1. DMH will develop an internal workgroup to develop a set of performance measures specific to housing and housing supports. 2. DMH will establish a process for evaluating outcomes across housing programs to drive decision-making.	DMH	1. Establish workgroup. 2. Housing staff participate in provider site review teams.	October 2012 Fiscal Year 2013
Objective #2: Improve Provider Performance and Accountability			
Action:	**Responsibility:**	**Performance Criteria:**	**Timeframe:**
1. DMH will clearly define the role of care coordination and incorporate it into regulation. 2. Individual service plans should have a housing component built in with clearly identified responsibilities. 3. DMH will evaluate mechanism for funding for non-billable service coordination.	DMH	1. Care coordination definition and role incorporated into regulation. 2. Regulations to require housing component addressed in service plans. 3. DMH to establish a mechanism for flexible funding for non-MHRS service coordination services.	Fiscal Year 2013
Objective #3: Increase Supply of Peer Support Specialists Working in Community Programs.			
Action:	**Responsibility:**	**Performance Criteria:**	**Timeframe:**
1. DMH will expand roles of Peer Support Specialists in regulations for PSH and Transitional Residential Services. 2. DMH will explore flexible funding mechanisms in order to increase the supply of Peer Support Specialists working in community programs. **(Note: See additional information in Goal Six regarding training of Peer Support Specialists.)**	DMH	1. Amendments to regulations. 2. Identification of flexible funding mechanism in order to increase the supply of Peer Support Specialists.	Annually 2012-2017

Objective #4: Improve Overall Engagement and Retention			
Action:	**Responsibility:**	**Performance Criteria:**	**Timeframe:**
1. Establish requirement in Home First program of minimum of one contact per month by CSW. 2. Expand the Monthly Visit Report to include content about consumers' level of engagement.	DMH	1. Incorporate requirement into regulation for Home First. 2. Measure number of consumers who are terminated from program for failure to comply with requirement. 3. Monthly Visit Report modified.	Fiscal Year 2013

Goal Six: Strengthen and Increase Community Workforce Capacity to Meet the Needs of Increased Numbers of Consumers Living in PSH

Goal Formulation:

Goal Five discussed the importance of the quality of services delivered to individuals. A core component of quality services is the quality of the workforce providing them. Workforce issues, particularly at the Community Support Worker (CSW) level, surfaced throughout this process and were identified as effecting the quality and consistency of services across programs and providers, success during transition, consumer engagement, and tenure in housing. As a result, workforce training is included as Goal Six in this plan. In order to ensure that training requirements are implemented, DMH will incorporate training topics into PSH and Transitional Residential Services regulations.

Training Institute and Learning Management System

DMH will explore the feasibility of funding courses within the DMH Training Institute to enable on-going training for staff specifically on the PSH model and philosophy, housing competency, and skill development related to independent living, recovery and wellness. The Learning Management System (LMS) implemented by DMH may be a tool that can be used to support this effort. The LMS is intended to provide web-based training to DMH, provider agency staff, and peer specialists. Staff from Saint Elizabeth's should also be able to receive training through the institute specific to the PSH model, capacity of PSH services to meet the needs of individuals with complex needs, preparing individuals to move to PSH at discharge, and coordinating the transition to PSH with the CSA and individual. Landlord/Property Manager training can also be made available regarding the PSH model, as can training on application processes, roles of CSAs and CSWs, services provided to individuals, and who to contact regarding consumer housing concerns.

CSW Certification and Training Module

Due to the wide variability in knowledge of CSWs regarding housing resources and requirements and how to access them, DMH will develop a housing module for CSW certification. DMH's plan to develop CSW certification provides an opportunity to develop competencies necessary to support people living in PSH settings. A housing module will be included that covers: recognizing early signs of potential housing crisis and intervening in an effective, timely way; engaging individuals who are refusing services or contact; flexible approaches to service delivery that allow for responsive and timely increase or decrease in frequency or intensity; and assisting individuals to develop critical skills, knowledge, and resources for successful and sustained independent living in the community.

Housing Liaison Training

In addition to a CSW certification housing module, DMH will develop a certification or standardized training for Housing Liaison positions. The training module will be competency-based and emphasize the critical knowledge, skills, and resources staff need in order to effectively deliver PSH and Housing Liaison services. The training module will also include, at minimum, material covered in the Housing Resource Guide, and how to develop transition and housing stability-focused service plans.

Goal Six: Strengthen and Increase Community Workforce Capacity to Meet the Needs of Increased Numbers of Consumers Living in PSH			
Objective #1: Increase role of Peer Specialists in PSH.			
Action:	**Responsibility:**	**Performance Criteria:**	**Timeframe:**
1. Designate specific roles of Peer Specialist in supporting individuals living in PSH.	DMH	1. Draft position description	September 2012
2. Require Peer Specialist role for each CSA team providing MHRS to individuals living in PSH settings.	DMH	2. Requirement added to PSH program standards and inserted into FY13 contract requirements.	January 2013
3. Review and revise as needed Peer Specialist Certification Training to ensure curriculum is competency based, includes structured practice and evaluation. Content to include housing specific knowledge and skill areas, and includes a component for Supervisors	DMH Training Institute	3. Revised Peer Specialist Curriculum	October 2012
4. Revise program rules and regulations to articulate eligibility requirements, functions, expectations for CSA certification (e.g. mandatory training for staff, # of Peer Specialists for every X # of PSH tenants)	DMH regulation revision workgroup	4. See Goal 4: Objective #1 Incorporate Peer Specialist staffing requirements into CSA regulations	May 2013
5. Increase the frequency and number of trainings for Peer Support Specialist certification.	DMH	5. Increased number of Peer Support Specialists for each year of Plan as compared with previous year.	Annual
Objective #2: Strengthen Community Support Worker Service Delivery Through Increased Training and Certification			
Action:	**Responsibility:**	**Performance Criteria:**	**Timeframe:**
1. Implement CSW Certification process.	DMH Training Institute	1a. CSW Certification curriculum developed.	December 2012
	DMH Training Institute	1b. Deliver first round of training.	March 2013
2. Develop/implement competency-based curriculum that includes structured practice and evaluation, and PSH as first module.		2. Housing Module developed.	December 2012
3. Develop competency-based component for			

Supervisors. 4. Revise program rules and regulations to articulate eligibility requirements, functions, expectations for CSA certification (e.g. mandatory staff training, CSW caseload size for PSH tenants)	DMH Training Institute DMH regulation revision workgroup	3. Supervisor Module developed. 4. See Goal 4: Objective #1 Incorporating CSW staffing and training requirements into pertinent regulations.	December 2012 May 2013
Objective #3: Standardize and Provide Training/Capacity Building for Housing Liaison Services across all PSH Programs.			
Action:	**Responsibility:**	**Performance Criteria:**	**Timeframe:**
1. Develop Job Description and delineate minimum functions for Housing Liaison position. 2. Determine HL to PSH tenant ratio necessary to meet housing coordination, landlord relations, and HQS related responsibilities. 3. Develop and implement HL certification process. Curriculum is competency based and includes structured practice and evaluation. 4. Revise program rules and regulations to articulate eligibility requirements, functions, expectations for CSA certification (e.g. mandatory staff training, HL caseload size for PSH tenants) 5. Provide on-going training and capacity building support to the Housing Liaisons in order to promote consistency and competency.	DMH Housing Staff in conjunction with DMH Training Institute DMH Housing Staff DMH Housing Staff in conjunction with DMH Training Institute DMH Regulations Revisions Workgroup DMH Training Institute	1. Document delineating DMH expected roles and responsibilities for position that can be incorporated in regulations, training materials, provider contracts 2.Minimum HL to PSH tenant ratio established 3a. HL Roles & Responsibilities Curriculum developed 3b. First round of HL training begun 4. See Goal 4 : Objective #1 5. Monthly meetings with designated DMH Housing Staff and community provider HL staff.	November 2012 November 2012 December 2012 March 2013 May 2013